

# Open Research Online

---

The Open University's repository of research publications  
and other research outputs

## An Interpretative Phenomenological Analysis of the Impact of Professional Background on Role Fulfilment: a study of approved mental health practice

### Thesis

#### How to cite:

Vicary, Sarah (2017). An Interpretative Phenomenological Analysis of the Impact of Professional Background on Role Fulfilment: a study of approved mental health practice. PhD thesis University of Manchester.

For guidance on citations see [FAQs](#).

© 2016 Sarah Vicary

Version: Version of Record

---

Copyright and Moral Rights for the articles on this site are retained by the individual authors and/or other copyright owners. For more information on Open Research Online's data [policy](#) on reuse of materials please consult the policies page.

---

[oro.open.ac.uk](http://oro.open.ac.uk)

An Interpretative Phenomenological Analysis of the impact of professional background  
on role fulfilment: a study of approved mental health practice.

A thesis submitted to the University of Manchester for the degree of Doctor of  
Philosophy in the Faculty of Biology, Medicine and Health

2016

Sarah Vicary

School of Health Sciences  
Division of Nursing, Midwifery and Social Work

## LIST OF CONTENTS

<b>List of Figures</b>	5
<b>Abstract</b>	7
<b>Declaration</b>	8
<b>Copyright statement</b>	9
<b>List of Figures</b>	
 <b>Chapter One: Introduction to the thesis</b>	 13
• Introduction to the chapter	13
• Definitions and terminology	13
• Aim and objectives of the thesis	
• Historical context	16
• Policy Developments 2000 onwards	18
○ New Ways of Working in Mental Health	19
○ Reform of the Mental Health Act: the reconfiguration of statutory roles	19
• Ideas upon which this thesis builds	21
• Structure of the thesis	22
 <b>Chapter Two: Literature Review</b>	 24
• Introduction to the chapter	24
• Search strategy and rationale	24
• Type of literature review and rationale	26
• Research studies upon which this thesis builds	29
• Instrumental aspects	31
○ Skills: coordination	32
○ Skills: interpersonal	34
○ Knowledge	37
• The moral framework	40
○ Independence	41
○ The social perspective	43
• The experience of approved mental health practice	49
○ Containment, emotional labour and dirty work	50
○ Physical and emotional risks	55
○ Interesting and dynamic work	59
• Conclusion to the chapter	62
 <b>Chapter Three: Methodology and Research Design</b>	 66
• Introduction to the chapter	66
• Interpretative Phenomenological Analysis	66
○ Ontological and epistemological positioning	67
○ Theoretical influences: phenomenology, interpretation and idiography	68
• Experience	73

• The choice of IPA	75
○ Aims and objectives	75
○ Grounded Theory	80
○ Ethnomethodology	84
• Research design	86
○ Ethics	87
○ Sample	88
○ Data Generation	90
○ Data analysis	93
• Quality and Validity	101
• Conclusion to the chapter	104
<b>Chapter Four: Presentation of findings</b>	<b>106</b>
• Introduction to the chapter	106
• The sample	106
• Being determined and undetermined	107
○ A straightforward, yet complex role	107
○ A role of discomfort and balance	115
○ A role of giving, taking and “smoothing”	120
• Abandonment and sabotage	127
○ “Role over”	128
○ Sabotage of “role over”	134
○ Sabotage of traditional roles	137
• Praxis	141
○ The use of person	143
○ The use of person: empathy and being protective	147
○ The use of person: defence of approved mental health practice	151
• “Pull”	157
○ Detrimental emotions	157
○ Positive, and contrasting emotions	161
• From “unclean” to “honorary social workers”	168
○ Convergence: “there’s no difference”	169
○ Overcoming divergence: from “unclean” to “honorary social worker”	171
○ Change to medical processes: nurses as approved mental health practitioners	174
○ Changes to approved mental health practice: nurses as Approved mental health practitioners	181
• “Popping someone’s bubble”	183
○ The illusion of safety	183
○ Dealing with the reaction, expected and unexpected	185
○ Bubble equivalents	191
• Conclusion to the chapter	201
<b>Chapter Five: Discussion</b>	<b>205</b>
• Introduction to the chapter	205
• The role in practice	206

○ The belief and the challenge	206
○ Instrumental aspects	207
○ The social perspective	208
○ “Smoothing”	210
○ Clean and dirty	213
• The role in praxis	220
○ Personhood	221
○ Influencing professional identity	224
○ The active use of dissonance	227
• Conclusion to the chapter	233
<b>Chapter Six: Conclusion to the thesis</b>	<b>236</b>
• Introduction to the chapter	236
• Implications for practice and research	236
• Strengths and limitations	240
• Reflection and reflexivity	241
<b>References</b>	<b>249</b>
<b>Appendices</b>	
• Appendix One: Literature reviewed but not critically analysed	260
• Appendix Two: Examples of critical synopses and analyses	264
• Appendix Three: Patient Information Sheet, Consent Form and explanation of a Rich Picture	278
• Appendix Four: Breakdown of sample	285
• Appendix Five: Topic schedule	286
<b>Word count 79727</b>	

## LIST OF FIGURES

	Title of figure	
Figure 3.1	Circles denoting relationship between researcher and participant	69
Figure 3.2	The hermeneutic circle in IPA analysis	69
Figure 3.3	Screenshot of annotation	91
Figure 3.4	Screenshot of anchored codes	92
Figure 3.5	Screenshot of memo on interview script of Nurse 01 with reflections made by researcher anchored back in transcript	92
Figure 3.6	Memo attached to a code	93
Figure 3.7	Excerpt from the researcher's reflective journal debating the use of the software package for IPA analysis	94
Figure 3.8	Screenshot depicting a model for one nurse participant	95
Figure 3.9	Screenshot of model for a social work participant	96
Figure 3.10	Screenshot of a section of the full report depicting one code and related quotes	96
Figure 3.11	Screenshot depicting a code memo, a transcript memo, a transcript and theories	97
Figure 4.1	Excerpt of a Rich Picture depicting the neighbours watching	107
Figure 4.2	Excerpt of a Rich Picture depicting report writing	108
Figure 4.3	Excerpt of a Rich Picture depicting juggling	110
Figure 4.4	Excerpt of a Rich Picture depicting service user in the corner	111
Figure 4.5	Excerpt of a Rich Picture depicting various pre-interview tasks	111
Figure 4.6	Excerpt of a Rich Picture depicting an AMHP prison	115
Figure 4.7	Excerpt of a Rich Picture depicting multiplicity of tasks	116
Figure 4.8	Excerpt of a Rich Picture depicting balance	117
Figure 4.9	Excerpt of a Rich Picture depicting the disintegration of the welfare state	123
Figure 4.10	Excerpt of a Rich Picture depicting role over	125
Figure 4.11	Excerpt of Rich Picture depicting doctor leaving	126
Figure 4.12	Excerpt of a Rich Picture showing doctors leaving	127
Figure 4.13	Excerpt of a Rich Picture depicting frustration	131
Figure 4.14	Whole Rich Picture depicting person in the middle	142
Figure 4.15	Excerpt of a Rich Picture with chain added to depict connection between participant and person	143
Figure 4.16	Whole Rich Picture showing various tasks and person at periphery	144
Figure 4.17	Excerpt of a Rich Picture depicting a raised eyebrow	147
Figure 4.18	Excerpt of a Rich Picture showing waste of time	148
Figure 4.19	Excerpt of a Rich Picture depicting a gun to the head	151
Figure 4.20	Excerpt of a Rich Picture depicting a rule book	155
Figure 4.21	Excerpt of a Rich Picture showing police car driving away	156
Figure 4.22	Excerpt of a Rich Picture illustrating participant being chained	157
Figure 4.23	Excerpt of a Rich Picture depicting a lovely assessment	159
Figure 4.24	Excerpt of a Rich Picture showing "pull"	162
Figure 4.25	Excerpt of a Rich Picture placing role in a bubble	182
Figure 4.26	Excerpt of a Rich Picture showing person in a bubble	183
Figure 4.27	Excerpt of a Rich Picture depicting relative's bubble	184

Figure 4.28	Excerpt of a Rich Picture showing aspects of an assessment	185
Figure 4.29	Whole Rich Picture showing circles spinning	186
Figure 4.30	Excerpt of a Rich Picture placing person in a bubble	190
Figure 4.31	Excerpt of a Rich Picture depicting relative's frustration	192
Figure 4.32	Excerpt of a Rich Picture showing lack of beds	193
Figure 4.33	Excerpt of a Rich Picture illustrating keeping thoughts safe	196
Figure 4.34	Excerpt of a Rich Picture depicting a dream bubble	197
Figure 6.2	Rich Picture: the thesis experience	244
Figure A4.1	Breakdown of sample showing gender, professional background and longevity	280

## ABSTRACT

The University of Manchester

2016

Sarah Anne Oakley Vicary

Degree of Doctor of Philosophy

### **An Interpretative Phenomenological Analysis of the impact of professional background on role fulfilment: a study of approved mental health practice.**

This thesis is concerned with the impact of professional background on role fulfilment. In the United Kingdom current policy in health and social care in mental health is underpinned by integration; the idea that responsibilities can be accomplished irrespective of profession. Approved mental health practice is one example of a psychiatric statutory role and function, until recently carried out by the profession of social work, which is now extended to other, non-medical, mental health professions. This thesis aims to explore the role and experiences of current practitioners in order to understand the impact, if any, of professional background on the fulfilment of approved mental health practice and the way in which it is experienced.

Qualitative data are generated through semi-structured individual interviews with twelve approved mental health practitioners: five nurses, two occupational therapists and five social workers and the use of rich pictures to supplement the interview discussions. Interpretative Phenomenological Analysis was applied to the verbatim transcripts.

Key findings were that approved mental health practice can be accomplished irrespective of professional background. Its practitioners require particular shared attributes, specifically a cognitive and affective capacity to deal with and use discord and to manage the disparate emotions that occur. Conceptualised in this thesis as “pull,” this finding constitutes a different understanding of the use of emotion in the workplace and provides evidence of a new emotional dimension; the active use of dissonance. Professional identity is also found to be influenced by approved mental health practice thereby turning on its head the original hypothesis of this thesis. Last, personhood is found to be an additional aspect of the moral framework for approved mental health practice and is being practiced in a different circumstance than previously considered.

The implications of this work are that it challenges the perception that approved mental health practice is synonymous with the profession of social work. It also revives the theory that its normative moral framework is inherently contradictory. The present study appears to be the first to associate personhood with approved mental health practice and shows role fulfilment as sophisticated emotion management, primarily the active use of dissonance. Both provide new insights into the enactment of approved mental health practice and are important issues for the future training and development of practitioners. The influence on role of professional identity may also help policy makers better understand the impact that new ways of working in mental health might have on traditional professional roles and boundaries in integrated services.



*Declaration*

No portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning

### *Copyright statement*

The author of this thesis (including any appendices and/or schedules to this thesis) owns certain copyright or related rights in it (the “Copyright”) and s/he has given The University of Manchester certain rights to use such Copyright, including for administrative purposes.

Copies of this thesis, either in full or in extracts and whether in hard or electronic copy, may be made **only** in accordance with the Copyright, Designs and Patents Act 1988 (as amended) and regulations issued under it or, where appropriate, in accordance with licensing agreements which the University has from time to time. This page must form part of any such copies made.

The ownership of certain Copyright, patents, designs, trademarks and other intellectual property (the “Intellectual Property”) and any reproductions of copyright works in the thesis, for example graphs and tables (“Reproductions”), which may be described in this thesis, may not be owned by the author and may be owned by third parties. Such Intellectual Property and Reproductions cannot and must not be made available for use without the prior written permission of the owner(s) of the relevant Intellectual Property and/or Reproductions.

Further information on the conditions under which disclosure, publication and commercialisation of this thesis, the Copyright and any Intellectual Property University IP Policy (see <http://documents.manchester.ac.uk/display.aspx?DocID=24420>), in any relevant Thesis restriction declarations deposited in the University Library, The University Library’s regulations (see <http://www.library.manchester.ac.uk/about/regulations/>) and in The University’s policy on Presentation of Theses

## Dedication

This thesis is dedicated to my parents who always encouraged my love of reading and study. They would both be very proud of their Welsh hill farm daughter.

## Acknowledgement

This thesis has been constructively critiqued throughout by Professor Alys Young and latterly Dr Stephen Hicks. I acknowledge their support unreservedly.

### The author

Sarah's research experience consists primarily of this thesis. She completed a Masters in Social Work which also involved some empirical research. In her current role as Senior Lecturer in another University, and previously, Sarah regularly conducts evaluations of local services.

## **CHAPTER ONE**

### **Introduction to the thesis**

#### **Introduction to the chapter**

This chapter sets the foundations for this thesis, discussing both its focus and purpose. Outlined are the overall aim and objectives along with the underlying questions which are placed in the policy context. Ideas upon which this study builds and the personal motivation of the author are provided as is the structure of the thesis. To begin, there will be an explanation of definitions and terminology and associated rationale.

#### **Definitions and terminology**

The mental health legislation discussed in this thesis is the Mental Health Act 1983, England and Wales as amended by the Mental Health Act 2007, England and Wales and referred to throughout as *the Mental Health Act*. This study's central concern is one amendment of the Mental Health Act, the introduction of the Approved Mental Health Professional; a reconfigured role that, in the original legislation, was exclusive to the social work profession and at that time entitled the Approved Social Worker. The role is now renamed the Approved Mental Health Professional to reflect this change.

Introduced under the Mental Health Act, the role of the Approved Mental Health Professional was first implemented in November, 2008. The fulfilment of it is the focus of the present study.

There are contemporary counterparts of the Approved Mental Health Professional in other countries of the United Kingdom. It is known in Northern Ireland as the Approved Social Worker and in Scotland as the Mental Health Officer, neither of which are opened up to other, non-medical, professionals. Nonetheless, throughout this thesis

there is a generic reference to all incarnations as *approved mental health practitioners* and the work undertaken as *approved mental health practice*. Where there is a need to refer to the particular embodiment, past or present, the specific title will be used in full. The one acronym present is AMHP which, when used, refers to the Approved Mental Health Professional in England and Wales.

Approved mental health practitioners have a statutory duty under the Mental Health Act to determine if the criteria for formal detention in hospital of an individual with a mental disorder have been met and, if so, to decide whether and how a detention, if recommended, should proceed. This assessment of mental disorder is a medical decision carried out by eligible doctors who recommend hospital admission based on this opinion. The process of decision making by approved mental health practitioners will be referred to as *an assessment*. In order to undertake an assessment, the decision maker is required to judge, given all the circumstances including an individual's social situation and the availability and suitability of alternative non-medical services, whether an application for detention in hospital is the best available option. This process will be referred to as *an application*.

In England and Wales, Guidance for Approved Mental Health Professionals is set out primarily in a Code of Practice that accompanies the Mental Health Act (Department of Health, 2015) which in effect translates the legislation into practice. Those mental health professionals eligible to be considered for this role are required to undergo a formal assessment of their competence as regulated by the Health and Care Professions Council (Health and Care Professions Council, 2013) and a process which, when successfully accomplished, is referred to as *being approved*. The Approved Mental Health Professional role is then a statutory one. It involves making a decision, about,

and being the applicant for, the formal detention in hospital of a person with a mental disorder.

The fulfilment of approved mental health practice has two aspects. The first is *instrumental*; this involves the coordination of the assessment, before and during, and includes taking into account and dealing with the person's social and domestic circumstances. The second is *moral*; this is the understanding that fulfilment is underpinned by an independent, non-medical perspective. Together these aspects have become known as *the social perspective*.

### **Aim and objectives of the thesis**

The overall aim of this thesis is to explore the role and experiences of approved mental health practitioners in order to understand what impact, if any, professional background has on role fulfilment. The focus of the study is currently practising Approved Mental Health Professionals in England and Wales and its objectives are threefold. The first is to explore perceptions of the role and the influence of professional identity on approved mental health practice. The second is to determine and understand professional identities as internalised and applied in approved mental health practice including in relation to attributes such as skills and values. The last is to examine any emotional and psychological aspects involved in undertaking approved mental health practice from each research participant's perspective, including practitioners' self-esteem and aspirations. The thesis has a number of underpinning questions:

- Does any profession have an exclusive ability to fulfil the instrumental and moral aspects of approved mental health practice?
- Is the non-medical perspective specific to the profession of social work?



- Can the social perspective of approved mental health practice be fulfilled irrespective of professional background?
- Does professional background have any impact on the fulfilment of approved mental health practice?

The questions arise from the policy context in which the research is taking place, the historical context, the previous research upon which it is built and the personal motivation of the author, as will now be outlined.

### **Historical context**

The historical development in England and Wales of approved mental health practice has its roots in the Poor Laws, later enshrined in the Mental Health Acts of 1930 and 1959. Mental Welfare Officers, as they were termed under the Mental Health Act 1959 and later Duly Authorised Officers oversaw admissions to hospital. Psychiatric Social Work meanwhile, a separate role, had its origins in nineteenth century philanthropy and undertook therapeutic work in child guidance clinics or mental hospitals. Both were perceived in two distinct ways; the former concerned with admissions, the latter with therapeutic intervention (Miles et al., 1961, Gostin, 1975, Rolph et al., 2003, Webber, 2008). Psychiatric Social Workers also were closely aligned to psychiatrists (Pargiter and Hodgson, 1959, Timms, 1964).

The concept of generic social work, and the creation of unified local authority social services departments in 1971 (Seeborn, 1968) in effect brought together the two mental health roles and arguably resulted in the loss of specialist social work mental health skills. A new impetus to mental health social work came with Mental Health Act 1983 which created the role of the Approved Social Worker. This role was to conduct a social assessment of the individual's circumstances and

investigate the possibility of using other services to avoid the need for a hospital admission, but there continues to be uncertainty in mental health social work about what the role of social work is in community mental health services.

Developments during the 1990s initiated integration of services in mental health and began to challenge the idea of discrete professional roles. A National Service Framework for Mental Health (Department of Health 1990a), mandated services across England which, most commonly, included the setting up of multi-disciplinary teams managed within Mental Health Trusts such as Community Mental Health Teams and later Crisis intervention, Early Intervention and Assertive Outreach Teams and also encapsulated in further policy (Department of Health 1990b). These developments signified a shift from social care to health care and the uncertainty contributed to the reported stress experienced by Approved Social Workers (Hudson and Webber 2012) and declining numbers (McNicholl, 2016). But, even though an integrated mental health practitioner role has become more commonplace after 2000 than before, this shift has not been wholesale, albeit has implications for whether or not other non-medical mental health professionals such as nurses, occupational therapists and psychologists, could be envisaged in an Approved Mental Health Professional role. Some mental health social workers were directly employed by Mental Health Trusts, and others remained located in social care services, employed by Local Authorities.

Meanwhile, under Section 75 of the National Health Service Act 2006, mental health social workers have been seconded to health care or Mental Health Trusts, but remained employed by Local Authorities. This increasing overlap between professional roles gave rise to a typology of attitudes; traditionalists, eclecticists and genecists (McCrae et al., 2004). Traditionalists favoured a distinct social

work discipline, eclecticists favoured a mixture believing that professional identity should be retained and generecists saw little difference between the various professions (McCrae et al., 2004 pp. 312-313). Other studies have explored and defended the influence of social work in mental health (Gilbert, 2003, Nathan and Webber, 2010), and explored the development of the Approved Mental Health Professional (Rapaport, 2006). More recently The College of Social Work established five roles for mental health social work which includes the provision of professional leadership for Approved Mental Health Professionals (The College of Social Work, 2014 p. 6). Different arrangements following devolution in the United Kingdom have resulted in the peculiarity of the Approved Mental Health Professional role which, unlike its counterparts in Scotland and Northern Ireland, has been opened up to other non-medical professionals in part to mitigate the effect of declining numbers of social workers.

### **Policy developments 2000 onwards**

Government policy in England and Wales regarding mental health workers in health and social care from 2000 onwards has been underpinned by a growing trend towards integration of the workforce and the belief that most tasks can be undertaken by any worker irrespective of professional background. Two broad policies encapsulate this development. The first concerns New Ways of Working in Mental Health as it is referred to generically. The second concerns the Government's reform of mental health legislation in England and Wales, and in particular, the outcome of this legislative process which gave rise to the reconfiguration of some statutory roles. Together, these policy drivers provide the context for this research.

### ***New Ways of Working in Mental Health***

New Ways of Working in Mental Health is a national workforce programme in England and Wales led, on behalf of the Government, by the National Institute of Mental Health in England (Department of Health, 2007) and determined by two aims. The first is to review traditional working practices of mental health professionals and the second to encourage multidisciplinary working. The overall goal of this policy is to encourage all professionals to share collective responsibility for providing appropriate mental health services. Concentrating initially on the consultant psychiatrist (Department of Health, 2005a), the New Ways of Working initiative was later directed to the wider mental health workforce including, of specific relevance to this thesis, social workers, nurses, occupational therapists and psychologists. Of most interest is the policy's stated rationale: to see how professional roles could be extended; to think in terms of competence not profession and to share knowledge, skills and competences across professional and practitioner boundaries (Department of Health, 2007 p. 10).

### ***Reform of the Mental Health Act: the reconfiguration of statutory roles***

Running parallel to New Ways of Working was the desire by the then Conservative Government to reform mental health legislation in England and Wales. After a protracted period of consultation and debate, the Mental Health Act was eventually amended only. Among the amendments, and mirroring the overarching move towards integration, is the introduction of reconfigured roles, the first being those of the Approved Clinician and the Responsible Clinician. Each of these Clinician roles can be filled by a range of mental health professionals including registered medical practitioners, registered psychologists, first level nurses whose field of practice is mental health or learning disability, registered occupational therapists and registered

social workers. In order to be able to undertake the role Approved Clinicians have to meet competencies as outlined in Schedule 2 of the Approved Clinician Directions and the associated guidance (National Institute for Mental Health in England, 2008). A Responsible Clinician is the Approved Clinician who has been given overall responsibility for a patient's case and who undertakes the majority of the functions previously performed by what had hitherto been known as Responsible Medical Officers, or consultant psychiatrists.

The second reconfigured role is that of the Approved Mental Health Professional opened up to the same mental health professionals as the Approved Clinician, with the exception of registered medical practitioners. The competencies for this particular role are outlined in Schedule 2 to the Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008 and the associated guidance (National Institute for Mental Health in England, 2008).

The first formal recommendation to include other non-medical mental health professionals as being eligible for approval as approved mental health practitioners was made by the Richardson Committee (the Committee), the group appointed by the Government to make recommendations for the reform of the Mental Health Act (Department of Health, 1999). Whilst in favour of retaining a compulsory assessment power, the Richardson Committee initially proposed more rigorous assessment requirements for detention over a shorter period. It also recommended the involvement of a judicial body to review any formal admission immediately after it had taken place. Whilst neither the more rigorous assessment periods nor more immediate judicial review were ultimately implemented, it was nevertheless in this context that the Committee suggested it might be appropriate to permit mental health workers from other professional backgrounds to be approved mental health practitioners (Department

of Health, 1999 p. 46). This suggestion was also a desire on the part of the Committee to reflect the contemporaneous practice of integration in mental health services. The proposal was met with a clear difference of opinion based on perceptions about which profession could best fulfil the social perspective.

On the one side of the argument was the view that this social perspective fits ‘naturally’ with social work (British Association of Social Work, 2005). Despite integration, social workers were deemed to remain independent of medical influence (Davidson and Campbell, 2010) and, being trained in the social sciences, they were also thought to best placed to understand the social dimensions of a person’s circumstances (Hatfield, 2008). The direct counter to this argument is that other, non-medical, mental health professionals are as capable, both instrumentally and morally, of undertaking approved mental health practice (Department of Health, 2005b, Hurley and Linsley, 2007). It is this difference of opinion that is the essence of the present study which builds upon previous ideas and personal motivation.

### **Ideas upon which this thesis builds**

The research undertaken in this thesis has its origins in two studies not undertaken by the author, both of which are discussed in more detail in Chapter Two. In summary, the first study suggested, probably for the first time, that approved mental health practice might be opened up to other non-medical professionals (Huxley and Kerfoot 1994). The second concluded that the approved mental health workforce in England and Wales was declining in numbers, either as a result of age or the impact on them of stress at the same time as the workload was increasing. Arguably, both studies applied increased pressure on policy makers to consider whether other professionals would be able to undertake approved mental health practice (Huxley et al., 2005).

However, the author has professional experience as an approved mental health practitioner and knows of colleagues past and present who have been approved mental health act practitioners. Her own experience and that of these colleagues is that whilst approved mental health practice is demanding, both instrumentally and morally, it is also accomplished with a sense of professional satisfaction and pride. This apparent, if anecdotal, dichotomy is what this thesis also seeks to explore.

Moreover, there is renewed interest in integration in mental health services and questions are raised about its effectiveness. This study aims to contribute to this understanding particularly in relation to approved mental health practice. Its findings will be relevant to the practice of social work, social care, nursing and occupational therapy within multi-professional, inter-disciplinary and integrated service contexts and to the examination of policy as it affects professional practice in mental health services.

### **Structure of the thesis**

This thesis is divided into six main chapters. The first chapter introduces the thesis clarifies the aims of it and outlines the policy, research context and personal motivation. The second contains the literature search and review and orientates the thesis in relation to previous and current research. The third chapter describes the methodology and research design, provides a rationale for the choice of methodology and describes how the study was undertaken. The fourth chapter presents the findings. This is achieved under six main themes, each of which is introduced and summarised. The fifth chapter discusses these findings in the light of the pre-existing research and relevant theoretical frameworks. The final chapter explores the implications of this current study for future practice and research and addresses the strengths and limitations. It also includes a commentary concerning reflexivity and reflection. Emulating the research technique

asked of participants, the author draws her own Rich Picture to evoke and represent the complex experience that has been the undertaking of this thesis.



## **CHAPTER TWO**

### **Literature Review**

#### **Introduction to the chapter**

This chapter provides a review of the published research in relation to approved mental health practice. To begin, there is an explanation of the process that has been conducted, commencing with the search strategy and rationale. Next, the type of review that was undertaken will be explained with reasons. The found literature will be discussed and evaluated using a thematic summary, the first theme focussing on the instrumental aspects of approved mental health practice and the second its moral framework. Last, there is an exploration of the literature that examines how approved mental health practice is experienced by those accomplishing it, a third and final theme. However, to begin, the two studies not undertaken by the author upon which this thesis builds are examined in detail. The search, subsequent review and summary appraises and synthesises the existing evidence concerning approved mental health practice as it is being used in this thesis and explained on pages 13 to 14, and thereby outlines the key ideas and theories that provide the backdrop for this thesis. The gap which this thesis wishes to fulfil will also be highlighted.

#### **Search strategy and rationale**

The purpose of the search was to locate empirical evidence relating to approved mental health practice. First undertaken when the author was beginning this study, the search was repeated each year to ensure thoroughness and currency. Key words, and combinations thereof, were inputted into a number of databases and websites using Boolean operators as follows:

ASW\* AND AMHP\*AND Approved\* AND Mental health\* AND Social work\* AND  
Nursing\* Occupational therap\* Psycholog\*

Approved\* OR approved social\* OR approved mental\* OR approved mental health\*  
OR approved mental health prof\*

Identity OR professional\* OR professional identity

The following databases were searched (in alphabetical order):

Academic Search Premier, Applied Social Science Index and Abstracts, Care  
Knowledge, CINHALL (EBSCO), PSYCH info, Royal College of Nursing, Social  
Care online, Social Services Abstracts, Swetswise, Web of Knowledge (ISI),  
Wiley

And also the Grey Literature (in alphabetical order):

British Association of Social Workers, Community Care, Centre for Mental  
Health, Department of Health, EthOS, General Social Care Council, Google  
Scholar, Health and Care Professions Council, Law Commission, Mental Health  
Act Commission, Mental Health Alliance, Mental Health in Higher Education,  
National Association for Mental Health, The College of Social Work, The  
College of Occupational Therapy.

Other search strategies included a citation search of key articles and authors by  
following up the reference lists of key papers and authors. A hand search was also  
undertaken of the following key journals (in alphabetical order):

British Journal of Occupational Therapy, British Journal of Psychiatry, British  
Journal of Social Work, Health and Social Care in the Community, International  
Journal of Nursing Studies, Journal of Mental Health, Journal of Psychiatric and

Mental Health Nursing, Journal of Social Welfare and Family Law, Journal of Social Work, Practice: Social Work in Action, The Journal of Mental Health Training, Education and Practice, Qualitative Social Work

Additionally, personal contact produced relevant material.

Agreed inclusion and exclusion criteria were set: that studies should be in the English language; that they relate to all incarnations of approved mental health practice in the United Kingdom including the different roles that exist (research relating to a specific role will use the correct role title); that they should be primary research including books, chapters and other reports and that they be in the date range 1980 and 2015. This start date was set to capture published literature in the build-up and implementation of the Approved Social Worker in England and Wales and the end date was set to the present day which would cover the build-up, implementation and current research concerning approved mental health practice. Included papers (32) are discussed in this chapter. Material that was excluded (29) but which nonetheless provide contextual and theoretical evidence is listed in Appendix One along with the reason for exclusion from consideration for this chapter where this has been the case.

### **Type of literature review and rationale**

Broadly speaking there are two types of literature review. The first, narrative, aims to summarise or synthesise, explain and interpret a variety of evidence on a particular topic but this is not necessarily collated in a rigidly planned way or to answer a strictly pre-defined question. The second, systematic, follows a tight system or process of collation, and also aims to synthesise what is defined as the best available evidence or primary studies that are judged methodologically robust. In addition, a systematic review makes transparent the process undertaken to those who read it so that it, and not just the

evidence it reviews, can be interrogated and the method replicated. As such a systematic review is viewed as being the most effective way of synthesising the best evidence and have their origins in medicine (Sackett et al., 1996). Attempts have been made to adapt these for other disciplines such as social work where they have attracted debate (Sheldon, 2001, Webb, 2001).

Both types of review have their critics; narrative is deemed as less structured or explicit and criticised as using findings in their own form with no attempt to provide a common matrix for analytical purposes (Mays et al., 2005 p.11). Systematic reviews are also, and increasingly, viewed as flawed not least because of the evidence, usually qualitative, that they exclude (Carr-Hill, 1998, Dixon-Woods et al., 2006) and are also sometimes viewed as reductionist, inflexible and resource intensive (MacLure, 2005, Taylor et al., 2007). Somewhat ironically, what might be perceived as a weakness of narrative reviews is also seen as a strength: their use is flexible, they can incorporate a wide range of evidence and they are usually less resource intensive (Mays et al., 2005, p.11).

There are then different types of review, each examining pre-existing evidence, each undergoing a process albeit one less strict than the other but for each their effectiveness is contested. Despite this, systematic reviews are now being undertaken in the social care field (Quereshi, 2004, Social Care Institute of Excellence, 2010 and Regehr et al., 2007) alongside the narrative review which retains its supporters (Rozas and Klein, 2010). Such activity is also taking place in the context of the development of the inclusion of qualitative research in systematic reviews or what are referred to as more inclusive forms of review (Dixon-Woods et al., 2006, p.27). In addition, tools are also emerging to enable the production of review and synthesis and, in turn, assess the quality of them, including the development of models in areas such as mental health social work (Gould, 2006).

The literature review undertaken for this thesis was primarily a narrative one using a recently developed tool (Wallace and Wray, 2011). This tool was used because it afforded the reviewer the opportunity to undertake an initial review of all found material, make a decision about that which was most suited to the study and in turn to analyse this in detail. This approach produced first, a synopsis of each piece of found evidence, be it qualitative, quantitative or a mixture of both. Second, it elicited a judgement as to whether this was a central text according to the research aim, objectives and questions. If deemed a main text, an in depth analysis was undertaken. Last, a thematic structure was produced and discussed in relation to the research question. This process, according to the progenitors of the tool, allows the main claims of the central texts to be discussed, critiqued and to be included in the review, whilst also enabling for the inclusion of peripheral texts if pertinent (Wallace and Wray, 2011 pp. 161-162).

So, for this thesis, once the search strategy had been put together and undertaken each found text was appraised, first by the completion of a synopsis recorded using the suggested format. Once complete and a decision made about relevance, a further critical analysis of the relevant texts was then undertaken. This analysis followed the suggested template. Examples of each of the initial synopsis and the critical review are provided in Appendix Two. Themes that emerged from this process were created and added to as the research process developed and as new primary studies came to light following later searches. This chapter follows this thematic structure echoing to some extent the two elements of approved mental health practice discussed earlier in Chapter One; the instrumental aspects of approved mental health practice and the moral framework. A last theme, the experience of approved mental health practice was also created. The relevant aspect of each piece of evidence is discussed within the theme to which it relates.

But first, the two studies not undertaken by the author and introduced in Chapter One as fundamental to this thesis, are explained in detail.

### **Research studies upon which this thesis builds**

As introduced in Chapter One, this thesis has its origins in two studies not undertaken by the author. Both studies aimed to review the provision and organisation of approved mental health services and to explore the contribution made by Approved Social Workers to the establishment and maintenance of a comprehensive mental health service. To recap, in the first of these studies it was suggested that approved mental health practice might be opened-up to other non-medical professionals (Huxley and Kerfoot 1994) whilst in the second it was argued that the Approved Social Worker workforce in England and Wales was declining at the same time as the workload was increasing (Huxley et al., 2005).

In more detail, the first study, a postal survey, received a high response rate (82 out of a possible 117 local authorities). The survey contained questions to elicit the characteristics of Approved Social Workers: numbers; rates per head of population; location and workload. Of most relevance to this review is the question asking respondents to try and predict the effect on deployment of approved mental health practitioners that might arise from possible reforms in services anticipated at that time. The authors claim, with high certainty from the evidence they provide, a number of outcomes. First, that the formula for calculating the number of approved mental health practitioners required, or the best distribution of them, is rarely documented and a complicated issue to explore and explain. Second, that decisions upon which the calculation of need was based also varied, with some local authorities approving all eligible workers and others nominating just some. Moreover, of those nominated, it was

found that some practitioners whilst approved were not active. The authors are unable to ascertain the reason for this dormancy and surmise that it might have been a consequence of initially allowing all previous workers to act as Approved Social Workers without the need to undergo additional approval.

Overall, the study concludes that Approved Social Work stood out as one of the few stable features in mental health services. However, despite this apparent stability the authors nonetheless proposed that other professions, such as community psychiatric nurses and probation officers could, with training, become specialist mental health workers including Approved Social Workers. It was feared at the time of the survey that local authorities' commitment to the deployment of such specialist workers might diminish and the authors appear to have considered the suggestion of opening up the role to other professionals as a possible solution (Huxley and Kerfoot 1994 pp. 320-321). This is the first study to make this suggestion but, other than proposing that this would mean a need for training, provides no other comment as to whether professional background might be of relevance nor does it remark on any instrumental aspects or moral attributes that might be required.

Huxley and additional colleagues undertook a similar follow up postal survey ten years after the original (Huxley et al., 2005). This work took place during the protracted period of debate surrounding reform of mental health legislation in England and Wales and the growing trend to make appropriate use of relevant skills elsewhere in the mental health workforce, in line with the policy New Ways of Working as discussed in Chapter One. The significance of this particular study to the present thesis is the conclusion that numbers of Approved Social Workers were declining at the same time as workloads were increasing (Huxley et al., 2005 p. 504). However, this apparent decline is not surprising. As the authors themselves comment, in the earlier study against which this

comparison is made, the number of inactive practitioners at the time of the first survey seemed unjustifiable (Huxley and Kerfoot 1994). Any decline has to be measured in the light of this. The authors provide other reasons, again based on conjecture. They suggest that the perceived downturn in supply is due to the lack of specialist mental health teaching on qualifying social work training courses as well as the increasing opportunity for qualified workers to seek employment in other sectors where pay and conditions were superior.

In addition to providing this, albeit contested numerical context, of most interest to this review is the second question which the authors of this second study posed: if Approved Social Work is opened-up to other professionals, what would be the nature, extent and relevance of required skills? Unfortunately, this question was deemed beyond scope of the study and remained unanswered. Further published papers were derived from this latter survey exploring the emotional aspects of Approved Social Work (Evans et al., 2005, Huxley et al., 2005, Evans et al., 2006) and will be discussed below. But first, this review turns to the instrumental and moral aspects which are the first of the overarching thematic themes found in the literature search and review.

### **Instrumental aspects**

The literature on approved mental health practice emphasises the importance of its instrumental aspects. These are categorised for this review into two elements, skills and knowledge.



### ***Skills: coordination***

As a way of informing the process of the reform of the mental health legislation, research was commissioned by the Department of Health to explore the issue of how Approved Social Work is performed in real-life situations. The resulting study was among the first to take a solely qualitative approach; the method used by the researchers was to observe Approved Social Workers as they undertook assessments (Quirk et al., 2000). Participants were located in two London boroughs and fieldwork was conducted in five separate teams: two hospital-based social work teams, two community mental health teams and an emergency duty team that operated outside usual office hours. Twenty assessments were observed taking place over a six-month period. Additionally, interviews were held with participants. The process of data collection and authentication, including member checking of field notes and write up, is described in what is a rigorous study that also demonstrates due ethical regard.

This study found that Approved Social Work requires multiple skills, attributes which the authors suggest would not easily be adopted by other professionals. In particular, safeguarding the social work function was recommended although there was no discussion or definition of the meaning of social work by the authors. It was also found that a social work function is valued by practitioners. Whilst, at first glance the recommendation and the finding seems to support sole retention of this function, the study does not conclude that accomplishing Approved Social Work is unique to the social work profession. What is suggested is that any professional responsible for coordinating assessments will require training for the demanding and multi-dimensional role and these are skills that might be difficult to replicate. Moreover, that the social work function means the consideration of social issues (Quirk et al., 2000 p. 9). The use

of social work to describe this element is therefore misleading since it does not necessarily mean the social work profession.

Nonetheless, the identification of the multiple roles of Approved Social Work which the study also found is of particular relevance to this literature review, most of which can be categorised as coordination. It was concluded that if assessments were to be organised successfully, approved mental health act practitioners would need ongoing contingency management skills. Meanwhile other abilities such as task-juggling and improvisation, cajoling and persuasion were also seen to be typically required, skills that one of the respondents reported as being able to successfully stage-manage (Quirk et al., 2000 p. 45).

The need to be able to coordinate assessments is also found in other studies but with no indication that such a skill is best suited to any profession. In one such instance semi-structured interviews were undertaken with a sample of the various professional disciplines involved in Approved Social Work in the community: eight doctors; five Approved Social Workers; five community psychiatric nurses; five ambulance personnel and eight police officers, all based in one National Health Service Trust in London (Bowers et al., 2003). This particular study sought to provide insight into how the assessment and detention process works and, whilst not stated explicitly, does so from the viewpoint of various disciplines. However, it is not always possible to understand where there might be a difference due to professional background. For example, one respondent is reported as saying that if one plate drops off then, it can affect the outcome of the assessment (Bowers et al., 2003 p. 963) but, as this quote is not attributed, it is not possible to know if the impact was the experience of one, or all backgrounds. It is reported that all groups of professionals spoke about the difficulties of organising a compulsory admission, in particular getting the requested personnel to

the right place at the right time and in so doing this reflects the Quirk et al. (2000) study. There is no discussion or indication however as to whether professional background matters.

Later research sought to examine routine practice of Approved Social Workers in one health and social care trust in Northern Ireland (Davidson and Campbell, 2010). Carried out in two phases, this particular study examined data collected from the official forms used to log activity during the assessment period along with a self-completed questionnaire by a sample of practitioners. Of relevance to this literature review, participants were asked to comment on their experience of working with other professionals. It was found that Approved Social Workers, but not all professional groups involved in the assessment, reported difficulties around coordination (Davidson and Campbell, 2010 p. 1622). This study is arguably limited in that it took place in one location only. Also, for the purposes here, it was undertaken in a legislative context which is not considering opening up approved mental health practice to non-medical professionals. Nonetheless, it provides further evidence that coordination is a key aspect of approved mental health practice.

### ***Skills: inter-personal***

Other instrumental aspects of approved mental health practice are identified in the literature review. These are skills similar to what might ordinarily be expected of professions whose work involves inter-personal activity and include communicating, building rapport and keeping things calm (Bowers et al., 2003 p. 965). Obtaining and asking others to share information about the person being assessed is also reported (Bowers et al., 2003), but attracts no other attention from the authors other than to comment that the quality and amount of information was seen to vary depending upon

location and timing of request. This finding mirrors the sense of information flows during assessments also found by Quirk et al. (2000).

Setting out to examine what is referred to as the assessment team or personnel involved in the assessment, including doctors as well as approved mental health practitioners, a further survey sought to explore the levels of access and communication, the barriers practitioners encountered and also to ascertain need for more training in managing severe cases (Fakhoury and Wright, 2004 p. 665). This study's design was a postal questionnaire sent out on a random basis to a selection of community mental health teams, collating data on demographics of practitioners and asking questions about communication with other professionals, training needs and information needs. It was concluded that the majority of respondents reported not being able to manage people with severe mental health problems and had information needs in various areas of their work. The research recommended better access to information on clinical assessments and mental health law.

But, this study is flawed. As the authors acknowledge, information was obtained only on respondents who were Approved Social Workers so therefore no comparison could be made with medical participants. Whilst it achieved a 56% response rate (111 questionnaires) the authors do not compare this with the overall number of potential respondents (3,463 as reported by Huxley and Kerfoot, 1994). In addition, the questions lack an opportunity for respondents to provide qualification. For example, when asking about the necessary training and skills to successfully manage people with severe mental illness answers sought either a yes or no response with no opportunity to indicate the reason. This reason might simply have been the desire on the part of the respondent to undertake ongoing development, an unclear interpretation of severe mental illness or the respondent may have been new to the role. The conclusions also

lack context. The authors state that the reported difficulties in communication between the respondent and General Practitioners are worrying not least because they are supposed to be working together as members of the community care team. This is a lack of operational understanding of the role of the aim of Approved Social Work. Nonetheless, for the purposes of the current review, this study does make some interesting comment in relation to the barriers approved mental health practitioners experience, namely bureaucracy, contact and communication problems. It goes on to recommend a proper discussion with a nationally representative sample of such practitioners concerning how to address these needs (Fakhoury and Wright 2004, p. 674), but such an exercise, if it has happened, is not available publicly.

The literature on the instrumental aspects of approved mental health practice emphasises the importance of coordination; a skill that is required throughout the assessment process. A significant analysis and discussion of these aspects was presented by Quirk et al. (2000) and to a lesser extent by Davidson and Campbell (2010). Data from several studies also indicate that in order to accomplish approved mental health practice there is a need to employ inter-personal skills (Quirk et al., 2000, Bowers et al., 2003). However, the relationship between professional background and these aspects has not been widely investigated and it is therefore not possible to ascertain from existing research whether professional background has any impact on approved mental health practice. One study (Fakhoury and Wright, 2004), claimed that Approved Social Workers lack knowledge both of mental health symptoms and of legal processes but is flawed. Nonetheless, the central importance of training for approved mental health practice emerges as a theme in the review indicating perhaps that approved mental health practice has knowledge that is expected and can be acquired through teaching. It is to this aspect that this chapter now turns.

### ***Skills: Knowledge***

In a large scale study undertaken in order to explore mental health social work more generally, it was concluded that Approved Social Work requires special knowledge and training (Fisher et al., 1984). The acquisition of knowledge through training has been explored in a number of studies. In one (Christian, 1985), the author sought to understand what is meant by appropriate competence, terminology which is sometimes used to suggest that an individual is deemed capable of undertaking a certain role once judged as such. Comparing and contrasting five sample cases referred for assessment under the Mental Health Act 1959 with five under the Mental Health Act 1983, the aim of the study was to explore whether there were any significant differences in the way in which assessments were conducted (Christian, 1985). However, no significant differences were found. Instead, lack of adequate resources, both of alternative services and also of training, was seen to be problematic. The lack of alternative services is an issue to which this review returns. Of significance to this part is the suggested lack of adequate training and the timing of these studies, undertaken as the 1983 Mental Health Act embedded.

In more recent years the impact of training has been shown to have a slightly more positive impact, although this is not consistent. One study concluded that although the Approved Social Workers interviewed held positive views about their training, in all cases there was room for improvement (Haynes, 1990 p. 196). Another extensive study indicates that the improvement may have taken place (Campbell et al., 2001). Using a variety of research methods to examine perceptions about the practice, supervision and management of Approved Social Workers, a questionnaire first piloted with approved mental health practitioner in two health trusts in Northern Ireland was later distributed to all such practitioners in the geographical area. Of relevance to this part of the review,

the questionnaire had a mixture of multiple choice questions on rates of satisfaction with various aspects of training and perceptions of confidence and competence in their role. Respondents were also asked to comment on what problems they faced. 243 responses were received representing 84% of the possible returns. Methods of data collection and analysis are reported in some detail and appear robust. The study found an experienced, well qualified cohort who had undertaken reasonable high levels of training both before and after becoming Approved Social Workers (Campbell et al., 2001 p. 168).

The value of training is reported as absent or poorly rated by nearly all respondents in a further study although this, whilst published in 2003, does not give an indication of when the actual research was carried out (Bowers et al., 2003). It is therefore not possible to orientate this reported finding with developments in formal training which may, or may not, have occurred nor, as was discussed earlier is it clear to which professional background such remarks are attributed. Indeed, this perception contrasts with the views of participants elsewhere who reported that mandatory training then offered to professionals wishing to become Approved Social Workers had far reaching benefits. In addition, it was reported that participants would like to see the training extended to other professional groups with similar statutory responsibilities (Walton, 2000 p. 411).

So far, the evidence of the impact of training is mixed. Almost a decade later, Parker (2010) analysed data from the first year of Approved Mental Health Professional training incorporated for the first time into a higher specialist award set at Master's Degree level and linked to the post-qualifying social work framework which was at that time regulated by the General Social Care Council. Data collected from one, first, year of the specialist training programme is examined to determine any impact of this higher

education level upon enrolment, retention and completion. Five Approved Mental Health Professional students from non-social work backgrounds were included in the cohort but, unfortunately for this review, no discussion was had about their different training needs or knowledge, if any. Instead, the study's author expressed some surprise at the relatively low take up by other professions of what was the then newly reconfigured Approved Mental Health Professional role.

Meanwhile, a different study concluded that training did make a positive impact on knowledge gained. In an analysis of concept maps drawn by participants before, during and after training as Approved Mental Health Professionals it was found that whilst one profession, social work, when embarking on training had a greater understanding of the role in comparison to mental health nurses, on completion, both demonstrated similar levels of learning (Bressington et al., 2011 p.564). This was a small scale exploratory study where the main focus is on the use of the method of concept mapping to illustrate how new knowledge is assimilated with existing understanding. Nonetheless, it might suggest that approved mental health practice knowledge can be taught irrespective of professional background. Almost as an aside, the potential for discrimination towards nurses whilst training as Approved Mental Health Professionals was noted and evidenced in direct quotes, a finding which is of interest in relation to process and impact.

The evidence presented in this section of the chapter suggests that approved mental health practice has a knowledge base which can be learned. To begin Approved Social Work is viewed as an especially problematic activity and there is agreement because of this that special knowledge and training is required (Fisher et al., 1984) so that the Approved Social Worker can approach an assessment in a less narrow and legalistic way (Haynes, 1990). According to several studies the training that has been undertaken



has had varying impact with some viewing it as lacking (Bowers et al., 2003, Christian, 1995, Haynes, 1990) and others regarding it as good (Campbell et al., 2001), even recommending it to other professional involved in assessments who were not Approved Social Workers (Walton, 2000). What is clear from the chronology of these studies is that the impact of the training has had an increasing impact over time. In direct relation to this thesis, the review indicates that the knowledge basis can be learned irrespective of professional background (Bressington et al., 2011).

So far, the review of the research evidence provides aspects of approved mental health practice to enable the smooth running of assessments and which have been summarised here as instrumental. However, one, seemingly mundane, attribute is also discussed and concerns the treating of those being assessed with dignity and respect illustrated by the example given of a worker saying he would do basic things like not sitting down without asking (Quirk et al., 2000 p. 27). This is a moral approach to approved mental health practice. Other studies in this review go on to provide a framework of the same which is the second overarching theme of this literature review to which this chapter now turns.

### **The moral framework**

The moral framework for approved mental health practice attracts much attention in the research literature but, on closer inspection, the views that are based on empirical evidence are arguably flawed and the remainder are viewpoints only. This section of the literature review will first explore the principle of independence. When combined with the instrumental aspects already discussed, these are referred to as the social perspective, a fundamental aspect of approved mental health practice.

## *Independence*

The importance of understanding independence as it relates to Approved Social Work formed part of one of the main studies upon which this thesis builds. In the context of the nature and extent of local resources where no resource other than hospital was available, this study suggested that was no option but to make an application for detention (Quirk et al., 2000 p. 46). As such, independence is viewed as illusory, a viewpoint echoing a similar one made ten years before (Prior, 1990). Participants in the same study were also reported as feeling constrained from going against medical recommendations (Quirk et al., 2000). These interpretations are pragmatic. The first attracts some consensus whilst the second dissent, albeit the disagreement about the latter is in relation to nurses. Published at the same time, one paper reported the view that adopting an independent position in relation to health professionals, particularly the psychiatrist, is a key element of Approved Social Work (Walton, 2000). It was also suggested that as nurses are in formal, hierarchical relationships with psychiatrists it is likely that even in an equivalent role they are bound to respond to such clinical instruction (Walton, 2000 p. 407). Walton's work will be discussed in more detail later. However, the impact of the lack of non-medical alternatives alongside the debate about what independence might mean are two fundamental principles upon which approved mental health practice is based.

Conducted five years following the introduction of the Approved Social Worker under the Mental Health Act, 1893 and, according to its author, in light of previous findings indicating that social workers in this role were not always able to uphold the principles of Approved Social Work, one study nonetheless found that independence is key (Haynes, 1990 p. 184). Twelve participants were interviewed following a semi-structured topic guide which asked the respondents to focus on an assessment they had

last conducted outside of usual office hours. This, the author claims, is when most emergency assessments tend to occur and the focus of her study. Several aspects are reported: the effects of out of hour's context upon the respondent's responses and decisions; the interaction of the respondents with other key professionals and, in particular, possible changes to the respondents' practice which might be attributable to the, then, new legislation. Three cases are presented from the transcribed interviews which were said to illustrate the experiences typically faced by approved mental health practitioners out of hours. Of relevance to the literature review here are the findings on how the role was perceived. From the cases illustrated and the accompanying discussion, respondents felt that their role had evolved from a largely administrative level to one of professionalism and independence [of medical influence] (Haynes, 1990 p. 196). However, this finding as the author acknowledges may not reflect the ideas of Approved Social Workers nor does this study include the perceptions of other non-approved workers. Being independent is however a key aspect and is also reported elsewhere.

One of the conclusions reached by Manktelow et al. (2002) was that by providing an independent voice outside of the medical hegemony, Approved Social Workers can protect civil liberties and prevent institutional excess (Manktelow et al., 2002 p. 459). These claims are not proven in their study albeit they are hinted at. The research design involved a triangulation of methods and data; a questionnaire, focus groups and semi-structured interviews. The questionnaire was distributed to all Approved Social Workers in Northern Ireland at the time of the research, 243 (84%) were returned and the data analysed. A sample of service users and carers were invited to take part in focus groups and mental health managers were interviewed using an interview schedule.

Characteristics of the workforce are described, along with frequency, location and timing of work.

Of interest to this review, participants were found to be a mature and well-qualified group of staff but, of the respondents, one quarter had not undertaken an assessment. Instead, less than one eighth were found to be responsible for more than one quarter of the total number of assessments. In the more detailed analysis provided it is reported that as a result of competing demands on their time and heavy workload out of hours, this 'caucus' may not adhere strictly to the principles of Approved Social Work and, in turn the ability to make an independent judgement. By way of contrast it is also reported that 68 percent decided not to make an application when requested to do so.

Independence of medical influence and the capability of any profession to engage with this is clearly a mixed picture in the literature requiring further exploration in this thesis.

### ***The social perspective***

Of the roles deemed as important and adopted by, or imposed on, Approved Social Work is that of social worker, which is qualified as being where social issues are considered (Quirk et al., 2000 p.9). Insofar as any future role holder was taken into account, this study strongly recommended that this social worker role be safe-guarded in decision making, thus ensuring that such social considerations are given due weight. This is not to suggest however that approved mental health practice is something that can only be accomplished only by social workers, but this particular viewpoint is a long held one and still pertains.

For some, a referral for assessment should be seen as an opportunity to offer a social work service (Fisher et al., 1984 pp. 185-190), a theme which repeats in this review but as will be shown, with the exception of one study, without robust empirical evidence to

support it. Viewed by one commentator as a distinctive and important, Approved Social Work is said to be a role which calls upon the use of knowledge and skills which when taken together are recognisably and distinctively those of social work (Sheppard, 1990 p. v.). Divided into four parts, Sheppard's book seeks to conceptualise what he refers to as the gatekeeper role and to provide an analysis of the behaviour of participants in relation to assessments. He does so focussing on the analysis of risk analysis with the aim of developing a framework for use when undertaking assessments. The core of the study was the examination of 120 referrals for assessment made to a mental health advice centre over a one year period in the late 1980s. The referrals originated from a variety of sources and were assessed by nine Approved Social Workers. The data were based on semi-structured interviews with these participants following each individual referral. Issues of access and interview schedules are clearly reported. Interestingly, Sheppard argues that this method was used to obtain accounts from the participants on how they perceived or accounted for what they were doing. In contrast to an earlier study (Quirk et al., 2001), Sheppard eschews direct observation. This he argued would give direct access to what Approved Social Workers actually did which, although of interest, was not the main concern of his study.

The questions used in the interviews concerned the social circumstances which led to the referral, issues of health and safety of the person and of others, the reason for disposal choice and finally where there were disagreements between professionals what alternative positions, if any, were adopted. The data were analysed in relation to the participants' accounts of risk for the person being assessed and the threshold at which an assessment became an application. From this analysis it was suggested that Approved Social Workers should develop a social risk orientation rather than a mental health orientation and Sheppard recommended the development of a conceptual

framework to analyse risk, referred to as the Compulsory Assessment Schedule. Whilst later tested (Sheppard, 1993), this Schedule has not since been adopted in approved mental health practice. For the purposes of the review here, Sheppard's claim that the knowledge and skill of Approved Social Work are those of social work therefore has no empirical evidence and is based on a viewpoint only.

The lack of empirical evidence concerning the direct influence of social work repeats elsewhere. Walton (2000) in a paper which draws extensively on views collected from 60 Approved Social Workers argues for a social perspective as brought, she contends, by the social work profession. However, no statistical breakdown is provided of the views collated, which is a weakness in relation to this particular review. Also, this piece was conducted and written by a trainer of Approved Social Workers and a former practitioner herself. It could be suggested that any views collated might be used in favour of the argument of retaining an exclusive social work role. Nonetheless, evidence is included showing that participants have a high rate of avoiding compulsion. Using statistics provided to her from a local team it is indicated that in the five years previous alternative approaches were found by Approved Social Workers in 19 per cent of cases where two doctors were recommending compulsory admission. There is nothing however to conclude that this decision to use an alternative is necessarily exclusive to social work even though Walton does comment that the majority of these assessments were instigated by community psychiatric nurses. This she argued suggested that those same professionals too were of the opinion that non-compulsion was no longer a workable option (Walton, 2000 p. 406). This hints at a view that social work is best placed to hold a social perspective, but is weak as it is based on supposition only.

Interrogating a database known as the Mental Health Act monitoring system used to collate statistics about mental health act assessments in six local authorities in the North

West of England, one long term study provided detailed examination of the characteristics of the population subject to mental health act assessments (Hatfield, 2000). This database collated information from monitoring forms designed by researchers and completed by Approved Social Workers each time they were asked to conduct an assessment of an individual with a view to their compulsory detention in hospital. The forms detail the characteristics of the individual subject to an assessment, of the referrer and of the outcome of the assessment. Regular feedback and support to the participating authorities is cited as evidence of the reliability and consistency of returns over the studied period. This study's aim was to develop a profile of each assessed individual over a long period, in this case nine years and, of particular relevance, to review the role of the approved mental health practitioner in the light of this analysis. This study concluded that the characteristics of the population subject to assessment indicated a close relationship between psychiatric severity and social disadvantage. As a result of this finding the author suggested that a social perspective [within Approved Social Work] was clearly indicated. Moreover, she went on to suggest that social workers are uniquely equipped to identify these issues (Hatfield, 2008 p. 1569). However, there is no evidence to support this suggestion other than the author's understanding of what training social workers undertake, such as in the knowledge of the social construction of problems and the nature of social context (Hatfield, 2008 p. 1554). Hatfield's assertion supports the need for Approved Social Workers to understand and engage in the social perspective. It cannot however be concluded from her study that understanding and accomplishing the social perspective is unique to the social work profession.

The belief that the social perspective is a central aspect for approved mental health practitioners that are social work practitioners has also been questioned. Bringing this

different perspective to the assessment was mentioned by less than one third of respondents in one study (Gregor, 2010) despite a question asking them to comment on what was important. This was an outcome which surprised the author, especially as she commented that these same respondents later expressed reservation about the opening up of the role to other professionals in the belief that these other professionals would not be able to uphold other perspectives (Gregor, 2010 p. 437). In terms of this review, Gregor does not state what these reservations are.

More recently, a literature review to explore the relationship between the Approved Mental Health Professional and occupational therapy was undertaken to try and develop an understanding of the fit between the two (Knott and Bannigan, 2013 p. 118). This work also wanted to explore why occupational therapists were not at that time taking up the role in any great number; just eight had been approved in 2012 (General Social Care Council, 2012). This paper is included here as it aimed to explore the perspective of occupational therapists and is based on a literature review. The authors report a search undertaken of electronic databases using key words, a strategy which is clearly documented. Themes from the literature review are discussed as a conceptual review focussing on the ideas within the papers rather than the methods used (Knott and Bannigan, 2013 p. 120). Of significance here is the suggestion that the social workers and occupational therapists share values, in particular the aspiration to address a person's whole situation. Other theoretical discussions based on their review include the relevance of the social perspective for Approved Mental Health Professionals and the perceived threat that this may be compromised if professions other than social work undertake the role and, as a corollary, that this would also undermine independence of the medical model. These concepts are important to this thesis but have no empirical basis. This paper is included in this section nonetheless as the one study from an



occupational therapy perspective that came up in the literature search, perhaps reflecting the low uptake of occupational therapists.

The one study on the social perspective that does base its findings on empirical evidence is that of a four-year research project exploring the organisation and practice of approved mental health practice role in Scotland using respondents' description of their own perspectives of the role (Myers, 1999). The study included in-depth interviews with 46 Mental Health Officers in a number of regions and service settings in Scotland. Respondents were said to perceive the skills, sensibilities and values they brought to bear on the assessment process were those of social work and that these same workers brought a specifically social perspective (Myers, 1999 p.109). This finding was, of course, the perception of the worker and does not seem to have been asked in the context of whether any other professional could bring such a perspective. On the other hand, some respondents were also reported as adopting different identities. This is symbolised by a hat metaphor; the wearing of a social work hat was said to imply one set of procedures, approaches and attitudes, and another hat those of the Mental Health Officer (Myers, 1999 p. 108). Myers discusses this finding in terms of what she calls the continuities and discontinuities between the two roles and describes two models. In one, the role of the Mental Health Officer is perceived as discrete and separate from social work. In the other it is absorbed into a broader social work role. For the purposes of the review here it might be possible to suggest that any professional could then, to extend the metaphor, take off their professional hat.

Of primary importance to approved mental health practice is the principle of independence. When combined with instrumental aspects, this has become known as the social perspective; the fundamental moral framework. For some commentators this perspective is said to be the domain of social work (Fisher et al., 1984, Sheppard, 1990).

But this is a viewpoint only and a contested one. Some suggest that approved mental health practice is a discrete role and by implication could be undertaken irrespective of professional background (Myers, 1990). Others contend that what needs to be dealt with during the accomplishment of the role requires a social work background (Walton, 2000, Hatfield, 2008). Whereas lack of non-medical alternatives mean that independence is illusory, so too in the literature there is an increased realisation that this is also the case in relation to the social perspective (Gregor, 2010). However, where instrumental aspects have their basis in a range of empirical evidence that which refers to the moral framework is less robust and especially so in relation to the question about what impact professional background has on approved mental health practice. There is an acknowledged lack of uptake by other professions of the Approved Mental Health Professional role (General Social Care Council, 2012) which may be due to structural issues rather than the impact professional background might have, but this is not discussed in the current research. The impact of professional background is the first focus of this thesis. The second is how approved mental health is experienced by practitioners. This next section of the review will now examine the literature in relation to this second focus.

### **The experience of approved mental health practice**

Data from several studies explores the experience of approved mental health practice. The focus of this section of the review is that data which refers to the practitioner. What follows is a discussion of the experience in terms of the concepts of containment, emotional labour and dirty work followed by a consideration of the literature relating to what is deemed the emotional and physical risks. In contrast, the data also indicates positive aspects in particular that approved mental health practice is interesting and

dynamic work which gives rise to competing demands and also requires effective management of the therapeutic relationship following assessment.

### ***Containment, emotional labour and dirty work***

In one small scale, qualitative study the views and perceptions of Approved Social Workers about their statutory roles and tasks were explored (Gregor, 2010). This study interviewed participants immediately prior to the transition from Approved Social Worker to Approved Mental Health Professional in order to capture the point of change and try and understand the complexities of the role and how participants related emotionally to it (Gregor, 2010 p.428). One non-practising and 24 practising approved mental health practitioners were interviewed by a sole researcher based on questions generated by a focus group of Approved Social Workers. A sample of the questions asked were listed and the research was reported within these categories. The areas of most relevance here are: motivation to undertake the role; continuing motivation; most important aspects of the role and most difficult aspects of the role.

No mention is made of ethical permission for this study which is carried out with fellow professionals, some known to the researcher, although it is acknowledged that the respondents may well have been uncomfortable in expressing their feelings because of this relationship. Moreover, the analysis is reported to have been done in accordance with the principles of Grounded Theory. The researcher states that she identified themes in the transcripts, later organised into sub-themes and reviewed by drawing on psychoanalytic concepts. This suggests that 'pure' Grounded Theory was not utilised, rather that the evidence was analysed to fit pre-existing psychoanalytical concepts. For example, Gregor focuses in particular upon containment and emotional labour or, what she refers to as the unconscious aspects of Approved Social Work.

In psychoanalytic terms, containment is the process whereby the distress of others' is managed without seeming to affect the person encountering the distress. Gregor cites Bion who used this psychoanalytical concept to explain how a mother processes difficult feelings for her child, returning them to the child in a more digestible format (Gregor, 2010 p. 432). The study concluded that containment is a required skill since an Approved Social Worker unconsciously processes a wealth of powerful emotions and feelings for service users, their families and sometimes other professionals involved (Gregor, 2010 p.432). Moreover, it was claimed that, if functioning well, the Approved Social Worker returned these feelings in a more manageable format for the person being assessed. But, if not functioning well, the practitioner experienced the distress and anxiety of the situation and did so as if it were their own. Unfortunately, these claims are not backed up by direct evidence nor, for the sake of this review, is it possible to tell if such skill is peculiar to any one profession. Gregor did comment that containment is likely to be required of the new professional groups that had become eligible to undertake approved mental health practice.

This same study also aligns containment with the sociological concept of emotional labour, the later concept developed by Hochschild (cited in Gregor, 2010 p.432) and refers to the need for a worker, albeit not explicitly, to demonstrate a calm and unfluctuating demeanour even when confronted by unwarranted provocation. Gregor (2010) believes that this concept can be applied to the respondents in her study as way of explaining how practitioners develop strategies to manage the associated emotional challenges. But, this claim is not fully substantiated when explored in detail. For instance, Hochschild noted three ways for workers to deal with the difficult aspects of work; the first to wholeheartedly identify with the assigned role, the second to act a role and distance oneself from it and the third to accept the division between the real self and

the on-stage self (Hochschild, 1983). Each strategy, according to Hochschild, bears risk; the first of emotional burnout, the second of being insincere and also of being unfulfilled, and the third of estrangement and cynicism.

Gregor (2010) does not analyse her findings according to these three outcomes. She states, that far from distancing their real self, a small number of the respondents openly and consciously engaged whilst acknowledging the inherent power. This might suggest the first of Hochschild's strategies is adopted but, this is not acknowledged by Gregor, nor is it then analysed in terms of the risk associated with this particular outcome. The concepts of containment and emotional labour do have some appeal for this thesis but in this particular study are not really evidenced by Gregor. Nonetheless, the direct quotes from respondents do provide insight. In addition, Gregor wonders why Approved Social Workers do not cognitively reconstruct their role and view emotional labour as a skilled aspect (Gregor, 2010 p. 438), a thought which is a more positive one. Whether such a skill specific to a particular profession needs further exploration in this thesis.

Dirty work is another sociological concept that has been explored in relation to emergency psychiatric work in general, and approved mental health practice in particular. Its progenitor, Hughes (1971), coined the concept of dirty work when examining the moral division of labour in occupations which is reported to have two aspects. The first concerns the behaviour of those with supposed higher status seeking to specialise in the most desirable elements of work whilst transferring the least desirable to, usually, inferior others. However, the relocation is not always possible, and in such situation workers justify having to do that which is least desired and sometimes also exaggerate its importance. The extent to which they justify varies. An earlier study in America (Emerson and Pollner, 1976) which, in terms of the date, falls outside the scope of this review is an important foundation for later studies. This study reported

mental health workers dealing with the so-called dirty work of compulsory admission. The act of compulsion was viewed as *doing to* and signalled a failure of therapeutic intervention or *doing for*. Nonetheless, in the study doing compulsory admission was legitimised and as such, and paradoxically, was sustained. Later studies in England that do fall in scope also explored the concept of dirty work in relation to mental health work.

The first of these found that most workers in the community mental health team studied categorised work that was not therapeutic as dirty and in turn its author argued that participants were, in dirty work terms, legitimising the transfer of it to others (Brown 1989). This assertion, in effect, applies the first aspect of dirty work. The remaining studies apply the second and are of particular relevance since they explore the concept in relation to Approved Social Workers (Quirk, 2008) and Approved Mental Health Professionals (Morriss, 2014, 2015). In a doctoral thesis, using data from the original Department of Health study (Quirk et al., 2001), Quirk (2008), viewed the anomalous nature of the multiple roles of the Approved Social Worker as dirty work because of the moral difficulties experienced during assessments. In other words, Approved Social Work is work that someone has to do and is thereby legitimised. In an interesting inclusion, participants, during the member validation of the data and its write up, had questioned what others might think of them if the work was termed as dirty work. This was a concern which is countered by the author when he extols the approach to Approved Social Work that he had observed, describing this as serious and solemn. Moreover, he suggested that it would be more shocking if the work was simply undertaken in a matter-of-fact way with no mention of its morally dubious dimension. Last, he concluded that Approved Social Work can have a therapeutic aspect and does

not just involve a compulsory admission. He is, in effect, legitimising Approved Social Work for the participants.

In a more recent study, the concept of dirty work was applied to data obtained from semi-structured interviews with social workers seconded to mental health trusts who also worked as Approved Mental Health Professionals, and undertaken as part of a doctoral study (Morriss, 2014, 2015). Using extracts from the interview data analysed through dialogical narrative analysis, participants are shown to view their work as having status especially when compared to social workers in the team who were not approved. Being an Approved Mental Health Professional was also viewed as more advanced than ordinary social work. The complexity and ambiguity of the work was also noted and included the dissonance experienced by practitioners, for example between the moral drive to empower whilst at the same time having a role which might involve the incarceration of someone against their will. Participants were also reported as perceiving the work as a positive or therapeutic intervention.

All of these findings support the aspect of the concept of dirty work that, in effect, dignifies or legitimates approved mental health practice. They also conflate the prestigious with the therapeutic; ambiguities and apparent contradictions in the combination of duties which fit fully with Hughes' original idea (Hughes, 1971 p. 309). What all of these study's conclusions miss is to explicitly link to Hughes' further contention, which is that the dirty work may be an intimate part of the very activity which gives the occupation its charisma. In the Morriss study, one participant views the role of the Approved Mental Health Professional as a good fit with social work but, as the author herself suggests, practitioners with different backgrounds may have given a different perspective to both this and the other findings. Also described is the emotional impact of the work including the suggestion that prolonged accomplishment might lead

to burnout, a less robust finding which is discussed in light of other empirical evidence but only to confirm that this is so. This review will now consider such risks.

### ***Physical and emotional risks***

Three studies exploring the emotional aspects of approved mental health practice were published based on the survey conducted by Huxley et al. (2005). Each will now be discussed.

The first relates to mental health social work more broadly (Huxley et al., 2005) but nonetheless, suggests that the themes which are identified could resonate with approved mental health practice specifically. This was argued given that 68 per cent of respondents (162) were identified as active Approved Social Workers. One of the themes include pressure of work. However, caution has to be applied; respondents came from 109 of 171 authorities and despite the authors' suggestion that the findings are transferrable, the results conflate generic and specialist work and are not easily separated. For example, in relation to pressure of work all direct quotes refer to assessments but are put in the context of the reported high levels of stress experienced by mental health social workers. This high level is indicated, the authors claim, by a score above four on a General Health Questionnaire for forty-seven per cent of respondents. It is not clear how or whether this figure relates to Approved Social Workers. Moreover, working longer hours than scheduled, getting paperwork up to date in order to see a case through to completion could actually be viewed as good practice and not, as relayed here, negative pressure. This is not to deny the importance of such findings, it is rather to view them differently. This need for balance is recognised by the authors when they suggest that there are many positive aspects to the work including making a real difference to people's lives, receiving support from co-workers and



managers along with access to good supervision. Nonetheless, it is concluded that carrying statutory responsibilities, while viewed as positive by many, raises stress levels and if this result is valid for social workers, then it might equally be valid for other professionals (Huxley et al., 2005 p. 1076). It is suggested that the proposal being made at the time of the study to permit other professionals to be approved to undertake statutory duties be revisited in the light of this evidence.

The second study, based on the data from the original research (Huxley et al., 2005) and using the same multimethod design, measured the results against tools commonly used to rate stress and burnout, in this instance the General Health Questionnaire score and the Maslach Burnout Inventory (Evans et al., 2005 p. 147). In addition, social workers were asked to keep a diary over a five-day period indicating primary and secondary activity undertaken in each hour time slot of their working day. The aim was to research the personal impact of carrying out the role, specifically the impact on pattern of work, job satisfaction, stress levels and burnout in order to understand the effects of statutory responsibility (Evans et al., 2005 p.146). This study is relevant to the section of the review because of this focus but, as the authors admit, the findings would have been more robust if more authorities had participated (109 out of 171 at that time), if numbers of staff selected in each had not been limited (four from each location) and there had not been ineligible staff included in lists that formed the sampling frame (Evans et al., 2005 p. 152). Nonetheless, it is concluded that Approved Social Worker status appears to increase the risk of burnout, a claim made even though scores for the individual features of burnout do not differ between groups [of non-approved and approved]. Moreover, both groups reported higher emotional exhaustion and depersonalisation than the reported norms for other mental health professionals, but also appeared to have more personal accomplishment (Evans et al., 2005 p.152). Such

findings are seemingly contradictory. Furthermore, one third of Approved Social Workers were said to be thinking of leaving but the study gives no indication as to the reasons. Demographic statistics of the participants indicate an ageing population. This may simply have been the reason, but is not discussed. Last, the study concludes that there is a risk that other professional groups who undertake statutory duties might experience similar levels of stress dissatisfaction and burnout as seemingly experienced by the Approved Social Workers in this study. It is not possible to deduce the correlation between Approved Social Work and higher levels of stress and burnout from the evidence presented. Furthermore, it is assumed that stress levels have only a negative impact. The findings relating to burnout appear to contradict and may be over exaggerated; just 8% of the sample could be classified as burnt-out according to the adopted scale and was said to be slightly more common among approved mental health practitioners, but is not statistically significant (Evans et al., 2005 p. 145).

The third paper (Evans et al., 2006) in essence repeats the findings of the second but also provides some explanation as to why those who did respond may have provided negative answers: that the survey was taken at a time of uncertainty for Approved Social Workers; that the return rate warrants a degree of caution and given the cross-sectional design of the study causal direction and, that it was not possible to determine causal determinants. Nonetheless, this study concluded that mental health social workers experienced poor job satisfaction and exhibited most aspects of burnout. Those who were Approved Social Workers were found to have greater dissatisfaction.

Approved mental health practice is viewed in many of the research studies relevant to this review as undesirable work. In answer to a question, what problems typically arise, the only question provided in the write up of one study (Bowers et al., 2003), it is perhaps not unsurprising that the focus of the responses is on negative aspects. It is not

known if this question was balanced in the interviews with a question asking about the positive aspects. The process of approved mental health practice is reported as being a likely negative one for the practitioner and is said to include the potential for endangering worker safety, with added descriptions of screaming and shouting as making the process more unpleasant along with reports of physical resistance making the process more confrontational (Bowers et al., 2003). As discussed earlier, no distinction is made in this study as to which professional this impacts on more. Feeling afraid or at risk is reported by more than a quarter of the respondents in a separate study (Davidson and Campbell, 2010) based, they suggest, on the participants in their study being left on their own in community settings with the person being assessed. However, three quarters of their participants did not report such negative aspects.

A more recent survey has reported using a similar method as its predecessors (Huxley and Kerfoot, 1994, Huxley et al., 2005, Evans et al, 2005, Evans et al, 2006). On this most recent occasion a survey was disseminated electronically through a national network of Approved Mental Health Professionals and via extensive promotion, although it is not made clear in the report what this promotion was. 504 responses were received. The study reports high levels of stress in these respondents (198 or 43%) which the authors claim is unacceptably high (Hudson and Webber, 2012 p. 2).

However, as the authors also conclude, it is lower when compared to the previous studies. Moreover, no mention is made of the relationship between the response rate and the actual possible respondents, estimated to be some 4,000 at the time of the survey (Godden, 2013). The study also reported that no significant difference was found in relation to stress or burnout between the professional groups because of the small sample of nurses participating. Whilst not to ignore what is reported about the impact of stress on practitioners, it is not clear what the views of those non-respondents might be.

They might be different and possibly positive. For the purposes of this review, the impact on different professional groups although included in the title for the study is not discussed.

In a separate study, respondents also cited stress and the emotional aspect of the work as being the most difficult aspect of Approved Social Work (Gregor, 2010). In this instance, stress was linked to coordination of the process and of the uncertainty linked to not knowing. The not knowing included what work might come in, how long the work might take, managing the emotions of the person, working in isolation once the doctor had left and finishing late and tired (Gregor, 2010 p. 437).

### ***Interesting and dynamic work***

By way of contrast, approved mental health practice is sometimes viewed as a positive enhancement to mental health social work. Gregor's study, for example, found that respondents presented as being comfortable with the authority, and accompanying power, vested in them and appeared to embrace and personalise it (Gregor, 2010 p. 435). This aspect of the role is little reported elsewhere, but is also balanced by one respondent's comment that somebody has to do it. Others in this same study viewed Approved Social Work as undertaking interesting and dynamic work and also concluded that while financial gain was sometimes available and motivated, respondents also expressed a wish to learn more about the law and about other aspects of mental health care as their drive. Other positive aspects included support received from colleagues, such as that of group discussion and peer support amounting, in some instances, to shared decision-making in the build up to an assessment (Quirk et al, 2000). In addition colleagues offer emotional support where there has been a difficult

assessment (Quirk et al., 2000 p.49). This finding is repeated, albeit briefly, in other studies (Campbell et al., 2001, Gregor 2010, Hudson and Webber, 2012).

Dealing with competing and often contrasting elements is a repeated experience of approved mental health practice as reported in the empirical research. Myers recorded one respondent describing this aspect as the 'dilemma of the two hats' (Myers in Ulas and Connor, 1999 p. 113). One dilemma is that of encompassing legal and welfare elements at the same time. Others included the combining of statutory and therapeutic roles and also the role of advocate for the individual whilst at the same time as a guardian of public safety, which might conflict. Quirk et al. (2001) describe the tension experienced by Approved Social Workers as role ambiguity: the practitioner at once both signs the formal application and also encourages the person to appeal against it (Quirk et al., 2000 p.45). Additionally, Quirk et al. (2001) note tension between what is termed the advocate and policeman-executioner, the former being the person representing the view of the person being assessed to other professionals and the latter being the one who locks people up against their will (Quirk et al., 2000 p.44).

The impact on subsequent working relationships with people compulsorily detained as a result of the assessment process attracts a mixed response in studies. For Bowers et al. (2003) four doctors and all Approved Social Workers reported no negative feedback, but three community psychiatric nurses spoke of expressed anger towards them. The lack of context here is a weakness; it is not clear whether the Approved Social Workers in this study were undertaking their role as part of a one-off duty and may be unlikely to have an ongoing need to work with the person being detained. This might in turn have affected their responses. The impact of invoking compulsory powers upon a pre-existing therapeutic relationship was also the focus of a study conducted by Hurley and Linsley (2007) following concerns by mental health nurses in particular that the then proposed

changes to mental health legislation to open up the role to other professions including nurses would compromise their therapeutic relationship, if they were to do so. In this study the authors aimed to explore experiences and perceptions about this aspect for Approved Mental Health Professionals. It is therefore relevant to this review as it both explores experience and perception and does so in light of the opening up of the approved mental health practice role. A qualitative approach to the study was adopted using data collection and analysis (Hurley and Linsley, 2007 p. 50).

In this particular study a questionnaire was distributed, in the first instance to all Approved Social Workers working in a single health trust, to determine if there was an issue to research and, if so, its scale (Hurley and Linsley, 2007). Twenty-two responses (73%) were received and semi-structured interviews were then undertaken with eight invited respondents to expand upon their questionnaire responses. The authors defend this method as a way of allowing respondents to describe their viewpoint and to fully explore their experiences in depth. Analysis of the questionnaire provoked three variations of the impact: the relationship was strengthened; the relationship required rebuilding, or was irrevocably damaged. The authors report the latter as a minority of the returns, which is true but actually it was three out of ten. This study concludes from its underpinning literature review aligned with its empirical data that there is little evidence to support that the therapeutic relationship will be irrevocably damaged. In addition, the authors suggest that mental health nurses could, with support, possess and value the very attributes which promote positive user-centred outcomes, more usually associated with social work. It is acknowledged that the research is limited because of numbers and geographic constrictions. Strictly speaking, the data collection while focussing on experience does not fully describe the philosophical phenomenological approach, if used. Moreover, the variables of pre-existing relationships clearly impact,

and indeed are recognised here and need to be explored further. Of interest to this review however is the assertion that mental health nurses are able to undertake the approved mental health practice role, with little difference.

There is a consensus among researchers that approved mental health practice has an emotional impact. For the purpose of this chapter the review has focussed on the impact it has on the practitioner. Research involves the psychoanalytical concept of containment (Gregor, 2010), the sociological concept of emotional labour (Gregor, 2010) and of dirty work (Emerson and Pollner, 1976, Brown, 1989, Quirk, 2008, Morriss, 2014, 2015). There are also reports of the physical (Bowers et al., 2003, Campbell and Davidson, 2010) and emotional impact on the practitioner (Huxley et al, 2005, Evans et al., 2005, Evans et al., 2006), most of which is reported as negative. However, what also emerges is that approved mental health practice, in direct contrast, is also viewed in a positive way. It is shown to be interesting and dynamic (Gregor, 2010) involving complexity such as dealing with contrasting and competing demands (Gregor, 2010, Quirk et al., 2000) and which also includes the ability to effectively manage the therapeutic relationship following an assessment (Hurley and Linsley, 2007). But, in the literature the positive aspects are mostly overshadowed by the negative which is misleading, as this review shows that such negativity is sometimes built on misleading use of statistics, a practice which to some extent persists even today when the view is that approved mental health practice is under pressure (McNicol, 2016).

### **Conclusion to the chapter**

This chapter has examined the relevant research into the question that underpins this study: what impact, if any, does professional background have upon approved mental

health practice and how it is experienced. Two studies upon which this thesis is based provide a statistical analysis of the numbers and distribution of Approved Social Workers and suggest probably the first time that approved mental health practice be opened up to other professionals. However, neither study examined any specific attribute nor skill that might suggest one profession was better suited to this role than any other. This present study seeks to do this.

Following a search and subsequent review, the found evidence was discussed using a thematic structure; the instrumental aspects and its moral framework, the first focus of this thesis. The literature on the instrumental aspects of approved mental health practice encompasses a range of methodologies and emphasises the importance of coordination, a skill that is required throughout the assessment process. An analysis and discussion of these aspects was presented. Data from several studies, again using a variety of methodologies, also indicated that in order to accomplish approved mental health practice there is a need to employ inter-personal skills. However, it is also shown that the relationship between professional background and these aspects has not been widely investigated. It is therefore not possible to ascertain from existing research whether professional background has any impact on approved mental health practice. This thesis seeks to provide this.

The evidence also presented in this review suggests that approved mental health practice has a knowledge base which can be learned. Viewed initially as an especially problematic activity, there is nonetheless a consensus that approved mental health practice requires specialist knowledge and training. According to several studies the training that has been undertaken has had varying impact but one that has improved over time. In direct relation to the underlying research questions in this thesis, it is indicated that the knowledge associated with approved mental health practice can be



learned and that this applies irrespective of professional background. This thesis will test this.

Of primary importance to approved mental health practice is the principle of independence. When combined with the instrumental aspects, these elements have become known as the social perspective; the fundamental moral framework for approved mental health. For some commentators this perspective is said to be the domain of social work. But the review here shows that this is a viewpoint only, and a contested one. Other studies also suggest that independence is illusory and there is an increasing realisation that this also applies to the social perspective. The instrumental aspects do have their basis in empirical evidence but that upon which the moral framework is based is less robust and especially so in relation to the question about what impact professional background has on approved mental health practice. This thesis seeks to explore the moral aspects of approved mental health practice in more detail.

There is a consensus among researchers that approved mental health practice has an emotional impact on the practitioner, most of which, using a mixture of methodologies, is reported as negative. However, these findings are misleading. What also emerges is that approved mental health practice is also viewed as interesting and dynamic work involving complexity such as dealing with contrasting and competing demands. This thesis wishes to explore the experience of approved mental health practice using a phenomenological methodology in order to understand this experience in depth.

There is one large scale empirical study which has not been discussed in this review and which at first appears highly relevant and therefore an omission. Conducted to monitor all work arising from the Mental Health Act 1983 which was referred to 42 social

services departments in England and Wales during the 12 months from April 1985 to March 1986, it would seem a key study (Barnes et al., 1990). However, the authors concede that their research did not include the experience of Approved Social Workers. This they viewed as a different study and too important to simply 'tag on'. For them, there was a dearth of evidence of this aspect of practice and they recommended further study of the actors, and, in particular what practice meant to them (Barnes et al., 1990 p. 10). No study has since done so. This thesis seeks to explore just this gap and to provide an in-depth analysis of both the role and experience of approved mental health practice.

## **CHAPTER THREE**

### **Methodology and Research Design**

#### **Introduction to the chapter**

The methodology used in this research study is Interpretative Phenomenological Analysis (IPA). This, a relatively new research methodology, was first introduced in the 1990s (Smith, 1996) and has gained momentum over the first two decades of its implementation, especially in health psychology. IPA is described by its proponents as a study of experience guided by three theoretical influences: phenomenology; hermeneutics, and idiography (Larkin et al., 2006, Reid et al., 2005, Shinebourne, 2011, Smith, 2004, and Smith et al., 2009, Smith, 2007). This chapter will discuss each of these influences and also examine what is meant by experience.

First, however, the ontological and epistemological positioning of IPA is explained including a discussion as to why IPA is considered the most appropriate methodology in relation to the aims and objectives this thesis, the role of the researcher and the dynamics of the research. The chapter will explore in detail two of the other methodological approaches which were considered and the reason why they, in particular, were not utilised for this study. There will be an account of the research design covering the processes that were implemented for obtaining ethical permission and access to and rationale for the sample, followed by a discussion of the methods that were used to generate the data and the analysis thereof. For the latter, Computer Assisted Qualitative Data Analysis was used to help manage the data. This chapter explains which tools were used to assist analysis and which not, with the reasons why. Last there is an examination of the quality and validity of this study comparing it with

the suggested criteria for IPA after Yardley, 2008 and Smith et al., 2009 and later debates (Chamberlain, 2011, Smith 2011a, Shaw, 2011, Todorova, 2011).

## **Interpretative Phenomenological Analysis**

### ***Ontological and epistemological positioning***

Committed to the examination of how people make sense of major-life experiences (Smith et al., 2009, p.1), IPA adopts an interpretive ontological stance. That is, it attempts to uncover the meaning and in turn the reality of people's experiences in the social world. IPA does not view reality as objective nor is it a methodological approach at the positivist end of the ontological continuum. It does not attempt to define or indeed obtain facts or seek the truth. Rather it seeks to understand the person's own experience, the meaning they make of it and, crucially, the interpretation which the researcher makes of the person's meaning. IPA's epistemological stance rests on the person's subjective account of experience. IPA protagonists refer to this process of the researcher making sense of the participant's sense-making as the double hermeneutic (Smith and Osborn, 2003) and this is the first definition of this concept. In IPA, engaging with the double hermeneutic is regarded as central to knowledge making. Additionally, knowledge comes about through understanding; an understanding which arises through empathy, but also through questioning. This dual approach to understanding is the second meaning of the double hermeneutic. The primary concern of IPA is the lived experience of the participant and the meaning they make of it. The end result is the account of how the analyst thinks the participant is thinking (Smith et al., 2009, p.80). IPA was itself a result of an intellectual debate in social psychology about which paradigm best suited which research agenda (Smith, 1996, Smith 2004).

Aside from the underpinning ontology and epistemology of IPA, other theoretical influences also exist. To understand these is important, both in fathoming how to implement the methodology, and in defending its use for this research study. The next section of this chapter now considers these influences and then orientates the methodology in relation to the primary aim and objectives of this thesis, including the role of the researcher and dynamics of the research.

### ***Theoretical influences: phenomenology, interpretation and idiography***

Phenomenology is a shorthand term which refers to both a philosophical movement and a range of research methods (Finlay, 2008, p.1). IPA is situated within a continuum of phenomenology which has description at one end and interpretation at the other.

Inaugurated in the early twentieth century by Husserl, the philosophy of phenomenology is concerned with the study of conscious experience. In descriptive, or transcendental phenomenology, the individual is said to engage with and make sense of phenomena, sometimes referred to as the natural or taken for granted attitude. This natural attitude is said to be people's everyday assumptions about how things are. In order to understand things as people experience them this involves moving away from the natural attitude through reflexivity, a process known as the phenomenological attitude. For Husserl, it is possible to get to the essence of an experience by putting aside this natural attitude or bracketing this off, a process referred to as the phenomenological reduction. Husserl's philosophy has been developed into a research method most notably through a movement known as the Duquesne school (Giorgi, 2010) where the emphasis is on a purist approach to phenomenology and especially a rigorous, scientific approach being adopted in order to get to the essence of the phenomenon.

Bracketing is an important concept in IPA and refers to the process whereby the analyst attempts to put to one side, temporarily, their own pre-existing understandings, such as theoretical, cultural, historical and contextual knowledge, in order to understand the given phenomenon. For Husserl this concerns putting aside the natural world and the world of interpretation in order to see the phenomenon in its essence (Gil-Rodriguez and Hefferon, 2012). This concept has been challenged not least by those who contend that such reduction is not possible and that the best that can be achieved is interpretation, the second phenomenological strand of IPA. This, the hermeneutic or interpretive phenomenology, is a version which views individuals and the world as a reciprocal relationship in which the both exists and are mutually understood. Consequently, its advocates contend that the best understanding of a phenomenon achievable is by interpretation only. In other words, meaning for the individual will always be influenced by the external world and will always be subject to previous or fore-understandings.

Heidegger, the main proponent of hermeneutic phenomenology does not accept that phenomenological reduction, as Husserl proposes, is possible. Rather, Heidegger formulates phenomenology as an interpretative activity. Bracketing is important to IPA and it uses it in two ways. First, it is used in the sense of phenomenological reduction. A researcher accepts that a participant's subjective experience exists and that they are trying to get to the essence of it by bracketing the natural attitude. Second, bracketing is used in the sense of putting aside preconceptions to enable the researcher to understand the essence of the phenomenon. This dual purpose has caused consternation among some phenomenologists who argue that to use bracketing in both ways does not meet generally accepted scientific criteria since the first, phenomenological reduction as it is used here, does not refer to the natural attitude, and the second, putting aside

preconceptions, relies on reflection rather than assuming the attitude of the phenomenological reduction (Giorgi, 2011 p.199). Apologists for IPA, however, argue the methodology merely borrows from the tradition (Smith 2010). In short, IPA conflates the two and translates the process as one that involves the researcher adopting an open, non-judgemental approach while at the same time being conscious of and holding back past or prior assumptions and understandings or knowledge.

The theory of interpretation, or hermeneutics, is a separate underpinning motivation for IPA and also influences the dynamics of the research and the role of the researcher. Originally hermeneutics concerned the interpretation of text, initially biblical, and involved an attempt to unearth what the author of the text originally meant. As such it combines linguistic and psychological elements; what the text denotes and what the author proposes. A further layer concerns the effect of the reader. Hermeneutics links with phenomenology through a strand of the philosophy which again includes the works of Heidegger. A phenomenon he argues appears through clues in the text which are integrally connected to that which might otherwise be latent or not overtly present in the text. Engaging with the text for Heidegger helps the analyst to facilitate the showing of the phenomenon and allows meaning, which is otherwise hidden, to appear. IPA borrows this concept believing that the researcher, in analysing text in detail, is able to discover that which lies dormant, whether the participant who provided the text or data is conscious of this or not, a second criterion for measuring the quality of an IPA study. Hermeneutics, also for IPA, influences the process of bracketing or adopting the phenomenological attitude. IPA proponents argue that thinking about a researcher's fore-understandings, and how that gives rise to new interpretations is a more enlivened form of bracketing and a cyclical process and as such something which can only be partially achieved (Smith et al., 2009, p.25). IPA translates the influence of

interpretation theory by suggesting that there is a perspective on the text or, in research terms, data, which arises through detailed and systematic analysis. For IPA apologists this results in insights which exceed and subsume the explicit claims of participants (Smith et al., 2009, p.23). The researcher, therefore, is inextricably linked with making possible the appearance of the meaning while also making sense of it. In short, the phenomenon cannot be known without the interpretation. Such detailed and systematic analysis is a further criterion for quality and validity. In this study bracketing is important for the researcher who has long established professional experience undertaking the role that is the object of the study. The researcher will be always mindful of the previous knowledge she has of the role and will try to put this to one side or adopt the phenomenological attitude albeit she is aware that this may not be fully possible. Bracketing is a fundamental criterion for quality and validity in IPA studies and will be discussed in relation to this study in Chapter Six.

A further hermeneutic concept of central importance to IPA is the hermeneutic circle. In essence, analysis is a cyclical process whereby the researcher tries to make sense of the participant trying to make sense of their experience, sometimes also referred to as the double hermeneutic and, as is usual with IPA, actively involving the researcher.

Visualised best as circles, one denoting the participant and another denoting the researcher, both come together at one point (Figure 3.1). This touching changes as the researcher engages in bracketing preconceptions, engages in interpretation of data and rethinking or seeing afresh their preconceptions, thus influencing the movement around the circle and the extent of the touching. This process is undertaken by the researcher who is in effect a vehicle for discovering meaning within the data, and is constantly cyclical or enlivened (Figure 3.1). Both processes are demonstrated in these Figures, albeit these are static models which do not readily convey the movement. In this study

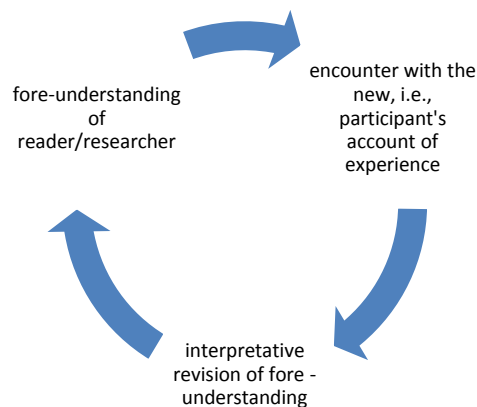


the researcher will engage in analysis over a protracted period of time and will study the text in detail. This affords the opportunity to see afresh any preconceptions and to engage in the enlivened cycle.



Gil-Rodriguez and Hefferon, 2012 p. 20

Figure 3.1 Circles denoting relationship between researcher and participant.



Gil-Rodriguez and Hefferon, 2012 p. 20

Figure 3.2. The hermeneutic circle in IPA analysis.

A final, yet as important, influence for IPA is a commitment to idiography. For IPA this means two things: first, a focus on participants in their particular context. This is not a

focus on the individual per se but rather, on the actual experience for that person in a specific context or as Smith et al. state, a reiteration of the complexity of the phenomenological concept of experience or on grasping the meaning of something for a given person (Smith et al., 2009, p. 29). Second, IPA recommends detailed examination of a single case, the examination of which is undertaken in the first instance, and sometimes remains as a case in its own right. However, there may also be a process which moves from examination of a single case to more general claims. Whilst recommending caution, IPA additionally allows examination of similarities and differences across cases. This examination it is suggested produces fine-grained accounts of patterns of meaning for participants reflecting upon a shared experience (Smith et al. 2009, p. 38). So, IPA is not setting out to make generalised claims but an in-depth understanding of the particular, which may, or may not, resonate with others in the same situation. This study seeks to explore the particular experience of assessment by approved mental health practitioners and will undertake one case in the first instance and then similarities or differences across cases, albeit with caution.

The assumption so far is that experience is a commonly understood concept. However, this is not as straightforward as it might first appear. This chapter will now discuss the meaning of experience as it is understood in relation to IPA and this study.

## **Experience**

An explanation of experience based on Dilthey (1976) is provided by IPA proponents (in Smith et al., 2009, p 2) in which there is said to be a hierarchy of different levels of experience. First, there is the elemental level in which a person is constantly caught up, unselfconsciously, in the everyday flow of experience. Next, there is a higher level in which a person becomes aware of what is happening or, has an experience. Finally,

there is the comprehensive level where the experience has larger significance. This comprehensive experience is made up of parts of life and it is these parts that are the focus, mostly, of IPA research studies. The example Smith et al. (2009) provide to illustrate the comprehensive level is that of a person undergoing major surgery and the impact this has. The parts: receiving the diagnosis; preparing for surgery; recovery; and so on, may be separated in time, but it is suggested are linked by a common meaning. This is an example that echoes earlier ideas about the importance of understanding a person's experience of the body during illness and health, including how this is lived with (van Manen, 1998). IPA seeks to engage with the person making sense of the comprehensive experience and especially with the meaning the person is making of this experience. The role of the researcher is to enable the participant to engage in the comprehensive level of experience which is produced when asking them to describe and reflect so that the phenomenon being study, in this case the experience of assessments, becomes comprehensive. In this study the researcher will ask the participants to explore their comprehensive experience of undertaking assessments.

In addition, IPA uses the concept of lived experience. Again borrowing from phenomenology and in particular Husserl (Finlay, 2011), and other theorists such as van Manen (1990), lived experience for IPA reflects a fundamental distinction of awareness which is more than just passing but rather is asserted. Experience is said to be lived and thus can be reflected upon. The idea of reflection is central to the understanding of experience and to the practice of research in IPA. Lived experience is encapsulated in IPA by describing a sequence of layers, each representing an increased degree of reflection (Smith et al, 2009, p.189). The first layer is based on Sartre's immediate flow experience that involves a minimal level of awareness or pre-reflective reflexivity. The second involves intuitive, undirected reflection including daydreams, imagination and

memory. The third layer, involves attentive reflection and occurs when an experience becomes something of importance, is registered as significant and as requiring attention. Finally, there is deliberate controlled reflection in which there is a formal analysis of pre-reflective reflections on past events. These layers present what is referred to as the bandwidth for the individual when doing their reflections by themselves (Smith et al., 2009 p.190). The researcher enters this so-called reflective loop of the individual to facilitate them to provide an account of their reflections. Thus, when being interviewed the individual will recount some reflection which they have already done, but the researcher will ignite new reflections, some relatively unconscious or, layers two and three, and some deliberate, or layer four. In research terms the researcher conducts the full, layer four, formal reflective phenomenological analysis on the transcript which is a record of the participant's layered set of reflections (Smith et al., 2009 p.190). In this study the researcher will, through the research techniques, a semi-structured interview and drawing of a Rich Picture, ask the participants to reflect on the past event of assessments and will also enter into the reflective loop, by the prompting of recall and reflection through these techniques and through detailed reading and analysis of the subsequent transcription of the interviews.

## **The choice of IPA**

### ***Aims and objectives***

It is now generally accepted that research questions and the purpose of the particular research study demand appropriate methodological approaches, or in some instances a combination of approaches. Understanding the theoretical underpinnings of qualitative research approaches, including IPA, is fundamental to any decision about which methodology is a best fit for a research study. In this thesis the decision rests on a

number of questions and include: what is the best fit given the aims and objectives of the research study, what is best given the practicalities for the role of the researcher and the dynamics of the research, what are the ethical implications and what is the researcher's ontological and epistemological approach. This section of the chapter will now consider the aims and objectives of this thesis in relation to IPA and continues with a discussion about two of a number of other methodologies, Grounded Theory and Ethnomethodology which were also considered, but which were judged, in the light of the original decision, to fit less well.

As has been seen, IPA connects with several core philosophical and theoretical ideas, but views them as complementary rather than competing, and picks eclectically from them. Rather than attempting to capture the essence of a phenomenon IPA, as its apologists suggest, more humbly aims to capture particular lived experience of a particular group of people. In addition, there is an emphasis on the convergence and divergence between participants (Smith et al., 2009 p. 202). This research study also wishes to do the same. It explores the experience of professionals, explicitly approved mental health practitioners. The purpose is to examine the parts of the experience of accomplishing the role and specifically the sense made of the comprehensive or lived experience, namely undertaking compulsory mental health assessments. Furthermore, this thesis explores the convergence and divergence, if any, between the understanding and experience of participants from different professional backgrounds. The process of bracketing will help the researcher guard against any assumption that their own professional background has and also as to whether professional background itself makes a difference.

Identity and emotional experience are said to be the main constructs which have emerged in IPA studies to date (Smith et al., 2009, p. 205). In addition to the immediate

aim of this research, its objectives include the wish to explore professional identities as internalised by participants including in relation to attributes such as skills and values. A second objective is to examine any emotional aspects involved from each research participant's perspective. In a review of studies reporting the use of IPA as their methodology, the predominant subject area was found to be illness experience (Smith, 2011a, p.14). The reviewer, also the methodology's progenitor, acknowledges that this is not surprising. IPA, he states, established itself first in health psychology and illness and is clearly an important area within health psychology (Smith, 2011a). This claim mirrors an earlier evaluation using a literature search of published studies in the arena of health psychology (Brocki and Wearden, 2006). Last, IPA is concerned with experience, especially human experience (Smith, 2011a, p.14). This thesis wishes to explore the human experience of approved mental health practice from each participant's standpoint.

The next consideration is the theoretical influences that underpin the choice of IPA for this research, adopting the phenomenological attitude, or bracketing. Researchers are urged to adopt an open, non-judgemental approach to the data while at the same time bracketing past assumptions, understandings and knowledge. Moreover, this attitude should be present throughout the whole research process with the researcher being urged to manage any intrusion of their own understandings constantly. This research study also adopts the phenomenological attitude. To do so the researcher will bracket off preconceptions. This aspect is especially pertinent since the researcher has personal experience of undertaking assessments and an up to date knowledge of current theory and research on approved mental health practice. In adopting the phenomenological attitude as it is understood in IPA, this will allow an opportunity to acknowledge fore-understandings and assumptions in order to get to the phenomenon. At the same time, it

is acknowledged that doing so is a recurring process and one which is not entirely achievable and it is inevitable that fore-understanding will impact. Reflection and reflexivity on the part of the researcher, including the dilemmas of bracketing (Tufford and Newman, 2010) will, therefore, be a key process. Its impact and the way it is managed in this thesis is discussed in more detail in the conclusion to this thesis. It is also explored in terms of quality and validity.

The role of the researcher and the dynamics of the research provide a further rationale for using IPA as the methodological approach in this research study. IPA is particularly suited to the professional skill base of the researcher who has long standing experience as a social work practitioner of interviewing in an open manner and also of the critical analysis of information. Both skills enable the double hermeneutic where knowledge is said to come about through in the first instance empathy, but also through questioning. However, it is also acknowledged that whilst the skills used are similar the purpose of a social work interview and an interview conducted for research purposes differs. The idiographic nature of IPA rests on examination in detail of a particular case. In this research study the case is the experience of an approved mental health practitioner and their experience of undertaking assessments. IPA studies are increasingly being conducted in subject areas other than health psychology including those being undertaken into the experience of health and allied professionals, as is the case in this thesis. In addition, IPA studies are increasingly being used by researchers from other disciplines. Of the four targets which Smith suggests as future developments for IPA, one is its use by associated professional research disciplines such as medicine (Smith 2011a). Although this is supported elsewhere, others muse on how readily researchers from this positivist tradition will accept the validity of such a methodology (Shaw, 2011). Certainly, this present study is being conducted by a researcher whose

professional discipline is other than psychology and where the subject area focuses on a different discipline, that of social work.

Meanwhile, it is agreed that the use of IPA is diversifying and that its future direction will spread and in particular that there is a need for its application to widen in order to allow consideration of socio-cultural situated-ness thereby also allowing a strengthening of the quality of IPA (Todorova, 2011). Smith's response is to defend the continuing focus which IPA must have on individual experience but, he also concedes, that in future an explicit social context would provide a more rounded synthesis (Smith, 2011b). Such epistemological adaptability has been discussed elsewhere in the literature, has been welcomed as a healthy state of affairs and is accepted as a way in which IPA could develop (Larkin et al., 2006, p. 117). Todorova contends that as researchers identify limiting or stigmatising social meanings, a constructionist epistemology will more clearly explicate and question them (Todorova, 2011, p. 36). Others agree that the epistemological basis of IPA should change, or as described it should have width as well as depth (Houston and Mullan-Jensen, 2011). This opinion is of particular relevance to this thesis since it is made in relation to the use of IPA as a research methodology in relation to social work, the practice of which Houston and Mullan-Jensen contend also attempts to understand meaning in the context of wider social processes. They suggest that if IPA is to be used as a qualitative research methodology in social work, it also needs to enable this understanding and its meaning (Houston and Mullan-Jensen, 2011). For them, this alignment will permit the qualitative social work researcher to understand both the psychological and sociological dimensions of existence (Houston and Mullan-Jensen, 2011, p.266). The epistemological basis and the potential shift to include more constructivist approaches are particularly pertinent when considering the use of IPA as the methodology for this study since it



wishes to understand explore an experience within its social and cultural context.

Meaning and context are said to be inextricably linked in qualitative research. This connection is also possible using IPA as a methodology. Smith's view is that while IPA focuses, first and foremost, on the individual and experiential, other studies will also include a more explicit social context and that the experience will be framed with a discussion of social and political forces which will be tackled in different ways (Smith 2011b). This research study accepts such a challenge and explores the comprehensive psychological experience of the approved mental health practitioner undertaking compulsory mental health assessments on the one hand. It will also be positioned in the surrounding sociological and political context.

There are different qualitative approaches to research including narrative methodologies where the focus is on that which is constructed through stories, discourse analysis where the focus is on the performative aspects of language and thematic analysis, as coined by Braun and Clarke (2006), for all methods that utilised themes. This section of the chapter now turns in detail to two particular methodological approaches, among others, that were considered, but not used. These are Grounded Theory and Ethnomethodology. A rationale is also provided.

### ***Grounded Theory***

Grounded Theory was developed in the 1960s by two sociologists (Glaser and Strauss, 1967) as a counter to the then dominant tradition of positivist approaches to research. Hitherto, there is little doubt that qualitative inquiry was viewed as invalid research. This was due to this perceived absence of robust techniques and in turn, lack of rigour. Since the publication of the seminal text describing Grounded Theory as a methodology and its techniques (Glaser and Strauss, 1967), a number of versions of the methodology

have emerged primarily as a result of a dispute about its nature (Strauss and Corbin, 1990). This dispute focuses, ironically, on rigour. This debate which began with the original protagonists is taken up by others who are less comfortable with the perceived positivist elements. One significant version is that encapsulated by Charmaz (2008). Here she positions Constructivist Grounded Theory as a middle ground between the quantitative and qualitative approaches (Puddephatt, 2006, p. 9).

Grounded Theory, and in particular Constructivist Grounded Theory was considered as a potential methodology in this research. This is not unusual according to IPA proponents who describe it as the main alternative (Smith et al., 2009, p. 201). However, there are differences which pertain, not least the room for creativity and freedom within IPA, which is said to appeal (Willig, 2001, p.69). As has been seen, there are debates and controversies associated with Grounded Theory and, while of historical and ontological interest, these are significant to any researcher who is adopting or, indeed, rejecting its use as a methodology. The traditional model can be said to be of its time and a product of the background of its creators. Grounded Theory focuses, just as IPA does, on the individual. However, the focus is on how the individual constructs and make sense of the world, or their reality and in turn a theory emerges as constructed by the researcher. This research study does not necessarily view the participant in this way, but rather as an individual engaged in making sense of their experience generatively which is in turn made sense of by the researcher. This research study wishes to explore personal and personalised experiences. Grounded Theory seeks to explain social processes (Willig 2001) and to inquire about how social structures influence how things are accomplished through a given set of social interactions (Starks and Trinidad, 2007, p. 1374).

There are also practical considerations for not using Grounded Theory. For example, the suggested sample type and size would have proved difficult in this study. Whilst both methodologies initially use purposive sampling to recruit participants who have experienced the studied phenomenon, Grounded Theory also uses theoretical sampling. The researcher adds further individuals to the sample to explore the found theory until theoretical saturation is reached. Whilst this does not happen at an exact point, sample sizes tend therefore to be large. IPA focuses on the particular individual in a particular context and a detailed account of their experience is said to be sufficient. In addition, the general rule of thumb espoused by those who conduct analysis using Grounded Theory is that data collection and the analysis of the generated data takes place concurrently (Glaser, 1992, Glaser and Strauss, 1967 in Charmaz, 2008 p. 83). Corresponding collection and analysis involves the researcher in undertaking the process of data collection and analysis as coterminous processes. The one, in essence, drives the other, and vice versa. The process moves through induction to deduction. Simultaneous involvement in data collection and analysis is said to mean that the emerging analysis shapes data collection decisions (Charmaz, 2008 p. 85). Grounded Theory is used by researchers to generate theory from the data which is then constantly compared with further data instances. Theory is said to be discovered by examining concepts grounded in the data (Starks and Trinidad, 2007, p. 1373) and the theories generated are open to generalisation and refutability. In this thesis it was not practical for the researcher to engage in such a reiterative data collection and analysis process. The researcher has full time employment elsewhere, participants are busy practitioners and repeat interviews not possible.

Choice of methodology is, however, not a mutually exclusive one. There is some overlap, not least in what Grounded Theorists refer to as theoretical sensitivity.

Approaching the research topic without the researcher being aware of the theory which already exists about that topic is a purist approach to Grounded Theory and echoes the attempt in IPA to bracket, or adopt a phenomenological attitude. The suggested effect of theoretical sensitivity is that the researcher is not influenced by any prior knowledge of theories, will therefore only see what is in the data, and will be open minded about the data and to any emerging categories and subsequent theory generated from it. For most commentators this approach is unrealistic. Researchers do not live in a vacuum, and will come to a research topic with at least some preconceived values or political and ethical commitments about the subject, if not about the theories which might underpin it.

Whilst Charmaz agrees that to delay a literature survey is an agreed technique in Grounded Theory, she is also pragmatic in her view that a researcher's disciplinary and theoretical proclivities shape the collection, content and analysis of data (Charmaz, 2008 p. 84). She commends the theoretical agnosticism offered by others, whereby the researcher retains doubt when entering into the data, looks for an interesting category and then explores how this category relates to the theory (Puddephatt 2006: 15). IPA also seeks to engage the researcher in this process.

Grounded Theory was considered as a methodological approach for this research study as both the ontological and inductivist approach to inquiry could fit. However, Grounded Theory sets out to generate theory of a particular phenomenon based on larger samples and where individual accounts illustrate the theoretical claim. In practical terms the recommended data collection and analysis to do this would not have been possible and neither is its epistemology suited. The role of the researcher, the dynamics of the research along with the ontological positioning is fundamental in this research study and fits more easily with IPA.

### *Ethnomethodology*

The term Ethnomethodology was devised in the early nineteen fifties and published in a series of papers brought together in a single book (Garfinkel 1967). Here the author describes Ethnomethodological studies as a focus on “the objective reality of social facts as an on-going accomplishment of the concerted activities of daily life, with the ordinary, artful ways of that accomplishment being by members known, used, and taken for granted” (Garfinkel 1967 p. vii). Ethnomethodology is a discursive methodology which has since been described in three parts:

- Ethno; which refers to members of a social scene
- Methods; which refers to the things that members routinely do to create and recreate the various mutually recognisable social actions or social practices
- Ology; which means the study of these methods (Rawls 2002 p. 6)

In short, Ethnomethodology is the study of the methods that members use to produce recognisable social interaction. The research questions which mostly fit this methodology are generally speaking about ‘doing being’ and to some extent fit this research question in this study when the experience of approved mental health practitioners is being explored. However, there is an important difference. In this study the researcher is exploring experiencing and interpreting being an approved mental health act practitioner; specifically, how approved mental health practitioners undertake a designated role, as they describe it, and as the researcher, interprets it. Other subtle differences pertain. For Ethnomethodology, the focus is not on the individual, their inner thoughts, feelings or emotions. Instead the focus is shared enacted interaction. Thus, the part the researcher plays in the interaction remains in the transcript and subject to analysis. In IPA, the experience of the individual, their inner thoughts feelings and emotions and how they make sense of experience is foremost. The part the

researcher plays is to prompt the telling of the experience and to encourage awareness of the comprehensive level in line with the earlier discussion in this chapter. The central role of the researcher thereafter is to interpret the telling in depth; the double hermeneutic of the researcher showing empathy and then questioning in trying to make sense of the participant trying to make sense.

Ethnomethodology also views the participants as actively making meaning in the interview situation with the interaction involving work between members to construct a mutually intelligible world. In IPA the interviewer prompts, but does not share. Their role is to allow the participant to explore the sense they are making of their experience in order to provide a rich, detailed, first person account (Smith et al., 2009, p. 56).

Ethnomethodology is concerned with language in use and that it is through shared, mutually agreed use that meaning is created. Language both builds understanding of reality and defines the way in which individuals enact identity. IPA rather relies on language but through the interpretation of the researcher even to the extent that the researcher may 'see things' in the data that the participant does not, as is the interpretative basis of IPA but which might also pose a dilemma. This dilemma is addressed through quality and validity and is discussed further below.

Ethnomethodology again sits well with this research study from an ontological perspective but this study will not use shared interaction to obtain meaning. Instead, the role of the researcher is to enable the telling and then to interpret. Not only is this a practical necessity it also underpins the need for this study to acknowledge the background of the researcher and the impact this has on the research study.

In summary, the best methodological fit in relation to the aims and objectives, the role of the researcher, the research dynamics for this thesis is IPA. Its purpose is to explore

the experience of approved mental health practice and specifically the sense made of this experience from the viewpoint of a particular homogeneous group. Furthermore, this thesis explores convergence and divergence, if any, between the understanding and experience of participants from different professional backgrounds within this same group. Identity and emotional experience are the main constructs to have emerged in IPA studies to date and are also the focus of this thesis. Meanwhile, adopting the phenomenological attitude, or bracketing is also of central importance given the professional experience of the researcher and also the need to put to one side pre-existing understanding of the personal professional background of the researcher and of the impact of professional background. IPA is also particularly suited to the professional skill base of the researcher and more readily enables the double hermeneutic as it is understood in both ways. Pragmatically, it was not possible, as is the expectation in grounded theory, to keep returning to points of data collection until theory has been saturated. IPA studies are increasingly being conducted in other subject areas including the experiences of health and other allied professionals and so it is in this current study. Last, this thesis explores the psychological experience of the approved mental health practitioner positioned in the surrounding sociological and political context, a recognised development of IPA.

### **Research design**

This section of the chapter outlines the specific research techniques that were used in this study the aim of which is to explore the impact of professional identity on role fulfilment. Data was collected once by means of a single semi-structured interview and Rich Pictures. The chapter will begin with ethics, sampling, data generation and data analysis. Last there will be a discussion of the thesis in relation to its quality and validity using the criteria first suggested for IPA (Smith et al., 2009) and that which has

since developed (Chamberlain, 2011, Gee, 2011, Shaw, 2011, Smith et al., 2009, Smith, 2011a, Smith 2011b, Todorova, 2011, Gil-Rodriguez and Hefferon, 2012).

### *Ethics*

Ethical permission for this study was sought through three separate routes: from the University's Research Ethics Committee; from the Association of Directors of Adult Social Services in respect of social work participants and from each of the three separate National Health Service Trusts that employed either the nurse or the occupational therapist participants. The process for obtaining this permission varied slightly. For the University it involved the completion of standard forms, compilation of Participant Information Sheets and Consent Forms and attendance, in person, at the University Research Committee to answer any queries. Questions were asked about the choice of method and timing of interview in relation to accessing the participant. Permission was granted. The process for the Association of Directors of Adult Social Services also involved the completion of a set form in addition to the same Participant Information Sheet and Consent Form, but attendance at their research committee in person was not required. No additional queries were raised and permission was granted. The process for obtaining permission from the health trusts was undertaken using the Integrated Research Applications System, an electronic system which requires completion of a generic form and one specific to each individual health trust research site. For two Trusts the site specific process also required undertaking online training concerning matters such as the safe and secure handling and storage of data, confidentiality and issues relating to avoidance of harm to participants and self. The researcher was required to achieve a successful pass. No additional queries were raised once this process was complete. Permission was obtained in each case and a Research Passport



(Reference number [13/18], study RG13-003] specific to the researcher enabled access to the sample and allowed data generation to proceed.

The Participant Information Sheet outlined the aims and methods of the study. It also explained the measures that were to be adopted to secure the confidentiality of each participant and of any person who may be discussed during the data generation, and of the safe storage of this data. Advice was also provided in relation to dealing with harm, were this to be a consequence of participating, either at the time or subsequently. The Participant Information Sheet also had attached an example and explanation of a Rich Picture with instruction for its use and purpose and was provided to each participant in order to enable them to make an informed decision about this part of the data generation process. The Consent Form confirmed that the participant had understood what was being requested and agreed to it. All forms were distributed through the gatekeeper at the point of access and revisited immediately prior to the start of the interview. The Consent Form was signed by the participant and countersigned by the researcher to acknowledge that the purpose of the research had been understood and consented to. The signed form was then securely stored separate to any data generated. A copy of all three documents is provided in Appendix Three.

### ***Sample***

The participant sample for this study was a purposive, homogenous one. The researcher wished to access participants who were all current approved mental health practitioners who shared the same experience, undertaking assessments, and for whom the research question would be meaningful. This sample method would also enable participants to give an in-depth account of the phenomenon in question. The sample was accessed, in the first instance, through a long established regional Association of approved mental

health practitioners. The chair of this Association, or gatekeeper, was contacted by email and also in person by the researcher to explain the purpose of the research and to seek access to the membership. The gatekeeper agreed to distribute by email a request for participation to each of the members. The Participant Information Sheet, Consent Form and explanation of the Rich Picture were attached to the email. Participants responded direct to the researcher and offers were accepted in the order in which they appeared. To begin, all of the respondents were social workers. In the absence of either nurses or occupational therapists, the researcher then asked the original gatekeeper if they knew of any approved mental health practitioners from these specific backgrounds. This resulted in a contact with a representative of a health trust that had supported nurses to train as approved mental health practitioners. In turn, this person distributed the request and those willing to participate in the study contacted the researcher direct. Again the offer to participate was accepted in the order in which it appeared. The original gatekeeper was also able to recommend other health trusts that had supported Occupational Therapists to train and contact was made by the researcher through this route. Named contacts in those trusts distributed the request and participants responded to the researcher direct.

It is suggested that studies using IPA should aim for an expert sample that is small in numbers (Gil-Rodriguez and Hefferon, 2012). The intention at the outset of the current study had been to recruit five of each of the eligible professionals; social workers, mental health nurses, occupational therapists and psychologists. Statistics available at the time of accessing the sample showed that social work practitioners made up the largest body candidates that were being approved (84%), nurses were the second highest but still a small percentage (15%) of the overall numbers and occupational therapists made up the lowest (less than 1%). No psychologist had at that time been approved

(General Social Care Council, 2012 p. 14). As anticipated, it was therefore relatively easy to access social work participants, nurses less so and occupational therapists the most difficult. Just eight occupational therapists had trained at the time of accessing the sample. Of these, four were approached by the gatekeeper and two agreed to participate in the study. Homogeneity of the sample focussed on the role only. Where respondents had a different gender this was noted as was longevity in role, albeit the years nurses and occupational therapists had undertaken the role were necessarily restricted by legislation. A breakdown of the whole sample with numbers, professional background and longevity in role is outlined in Chapter Four.

### ***Data Generation***

For this research study data were generated in two ways. The first was a semi-structured interview based on a predetermined topic schedule. The schedule contained a preamble to the interview and information to reiterate to the participants afterwards. There were seven short questions and a number of prompts designed by the researcher to allow participants to describe and discuss their experience of assessment and their role as an approved mental health practitioner. The topic schedule is available in full in Appendix Five. The interview took place just once in a work location and time of the participant's choosing. Immediately before the interview participants were afforded up to ten minutes to draw a Rich Picture of their chosen assessment(s), an activity about which they had been made aware when being accessed and as they agreed to participate. Each participant was provided with one A4 sheet of good quality white paper and a black ink pen. Participants were left alone when drawing the picture. The researcher then returned to the room and interview then went ahead using the topic guide as a prompt. The interview included an opportunity for each participant to talk about their drawing. After the interview participants retained a photocopy of their Rich Picture if they chose to do

so. The original was retained and stored by the researcher. Each interview was audio-recorded with the participant's permission, using an application on a mobile device. This method had the benefit of being quiet and unobtrusive. The battery life was also long lived and meant that there were no mechanical interruptions. Transcription was undertaken by the researcher alone. Transcription involved typing each word spoken by both the participant and the researcher but did not include the length of pauses or other elements such as where the participant may have laughed or paused. The transcripts were a vehicle for interpretation of meaning and not as is the case with other methodologies an analysis of the actual words, shared interaction, discussion or narrative. The process of transcription allowed the researcher an opportunity to recall the interview, to become more familiar with the transcript and to begin the process of analysis.

Semi-structured interviews are a recognised method for generating data in qualitative research studies where they are said to offer an opportunity to acquire in-depth first-person accounts of a participant's experience (Kvale, 2007). Moreover, for IPA they are said to facilitate the elicitation of stories, thoughts and feelings about the research phenomenon (Smith et al., 2009, p. 56). The interviews for this study were semi-structured in that the topic guide (see Appendix Five) was used by the researcher for prompts focusing on the phenomenon, but it also meant that the interview could be flexible, adaptable and led by what the participant was saying. Whilst more structured methods are perceived as not affording the opportunity to engage in full or in-depth disclosure, imaginative methods, which do allow such discovery, are encouraged. In this study participants were also asked to draw a Rich Picture of an assessment. Rich Pictures were first used as part of Soft Systems Methodology (Checkland, 1980) and involve asking participants to draw using symbols and words a representation of a

complex phenomenon that is being examined. A Rich Picture has two purposes. The first is to elicit a response about the phenomenon and the second, to record this pictorially. In line with this particular method, participants were also asked to give the drawing a name. Supplementing the interview data with a second method, in this instance the drawing of a picture, was designed to further enable the revelation of thoughts and feelings of the participants in this study who were asked to talk about their drawing as part of the semi-structured interview.

Drawing, a term which refers to the process and the product, comes under the umbrella of visual research methods and its use is increasing in many areas of research (Theron et al., 2011) including applied research, such as nursing (Kearney and Hyle, 2004) and social work (Hus, 2012). There are a number of ways in which drawing can be used as a research method. Examples include line drawings and cartoons, some of which are produced by the researcher, some by the participant and some co-produced. In this thesis, the drawing was produced by the participant. The rationale for its use in generating data have been discussed more fully elsewhere (Matthews, 2013). In summary, this includes: its simplicity; the only requirement is a pen and paper, and its tangibility; once produced it can provide a focus for conversation. In addition, since the production of a drawing is said to use different cognitive processes its use can also provide an opportunity to access thoughts, feelings and emotions in other ways (Guillemin, 2004, Kearney and Hyle, 2004). This method of generating data was a particular attraction in this research study given that participants hail from professions that ordinarily use verbal and written communication predominantly. The method was used in order to evoke thoughts and feelings in an unfamiliar way and thereby allowing a further opportunity to explore meaning for the participants that might otherwise be hidden. However, the use of the drawing in this study has been to elicit data only.

Analysis was undertaken of the transcribed text and the drawings, either whole or in part have been used to illustrate the findings. The process of analysis, including its rationale, is now discussed.

### ***Data Analysis***

Once transcribed the scripts were formatted as recommended (Bazeley and Jackson, 2013 p.59) and inputted into a computer software package, QSR NVivo 10. Each transcript was assigned a code: for social workers this began with the letters SW followed by a number from 01 to 05 and a capital letter to indicate whether it was the interview (I) or Rich Picture (RP). This was repeated for nurses except they were allocated the letter N and a number from 01 to 05 and for occupational therapists this was OT and numbers 01 and 02. Each participant was given a name of the same gender but not their own. Photographs were also taken of each of the Rich Pictures and also imported into the software package.

The software package is designed to manage the data. Analysis took place over a period of two years and was undertaken by the researcher alone. The length of time was pragmatic in that the researcher was undertaking the research part time, but more importantly, it also was determined by the methodology as discussed earlier in that such in-depth attention helped to allow the hermeneutic circle to be constantly cyclical and, in IPA terms, enlivened. The researcher started with one script, N01I, which was read and reread, a script that was chosen because, from recall of the interview and through transcription of it, this appeared to the researcher to be particularly interesting and detailed. Each script received similar attention but were not studied in any particular order thereafter. The process of analysis began using three of the tools provided within the software package.

The first of these tools was the annotation of the script. This was undertaken in order to clarify any terminology that was being used. For example, participants frequently referred to Jones, a shorthand reference to a widely used Mental Health Act manual. This process of annotation is highlighted in pink in Figure 3.3. The highlighted area can be clicked on when returning to the script as a later time to provide the analyst with a description.

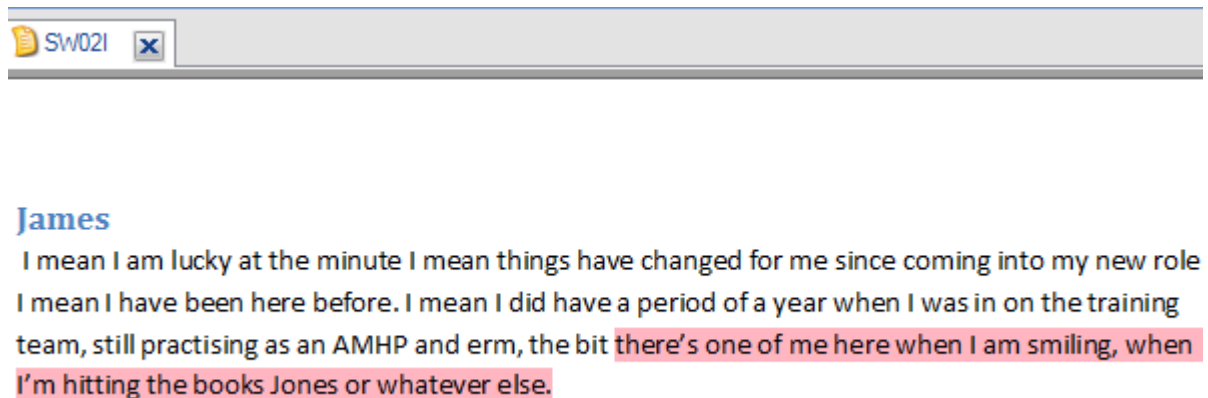


Figure 3.3 Screenshot of annotation.

The second tool was the identification and naming of codes. Coding is one method of working with qualitative data that provides an abstract representation or theme noted by the researcher and can be descriptive or interpretative. The software used in this study allows codes to be anchored in the text which had given rise to them and is demonstrated in Figure 3.4 where the code, atypical, is shown to have excerpts of the interview scripts from two nurses N02I and N03I to which is it anchored:

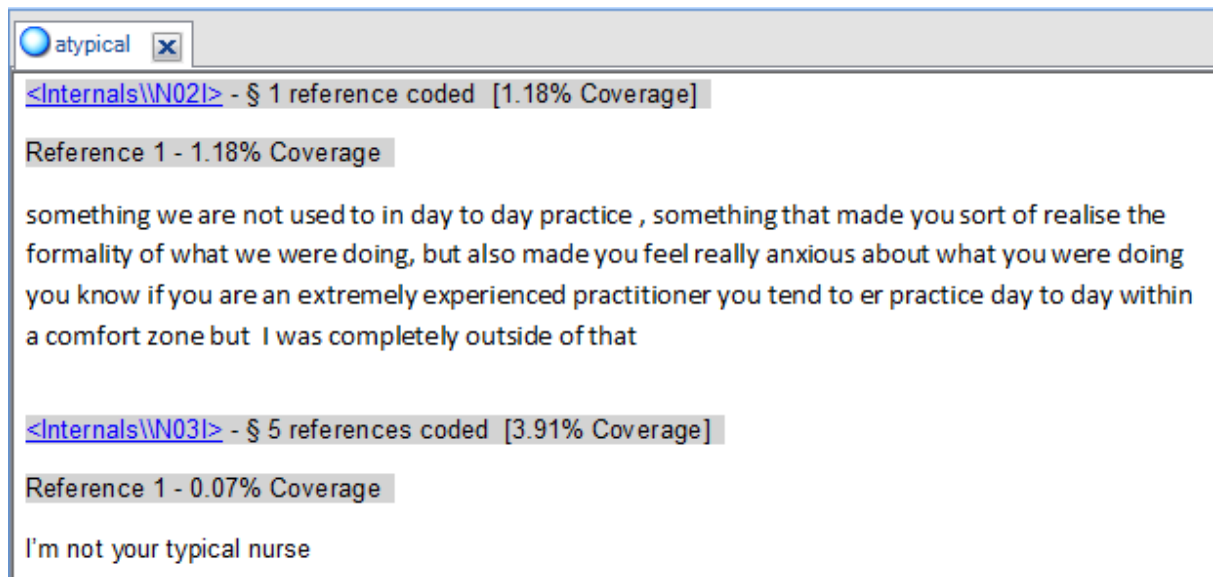


Figure 3.4 Screenshot of anchored codes.

The third tool was the creation of a memo for each script in which the researcher made reflective notes about that script as they occurred during the reading and rereading.

Again the software allowed for these thoughts to be anchored as shown in the highlighted areas the interview script of one nurse, N01I as demonstrated in Figure 3.5.

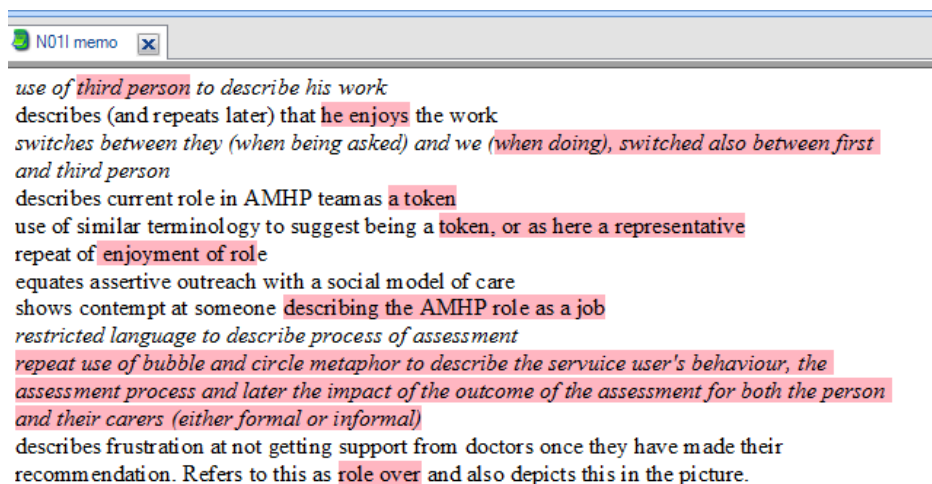


Figure 3.5 Screenshot of memo on interview script of Nurse 01 with reflections made by researcher anchored back in transcript.

The software package also allowed the creation of memos for each code. This process allowed the researcher to record their thoughts about the process of analysis and the



content of the code. In IPA terms this process as enabled by the software package also affords transparent way of moving from first order to second order thinking, the lack of which is often a criticism in IPA studies (Larkin et al. 2006 p. 103, Vicary et al., 2016 p 11), while at the same time allowing an audit trail to anchor the reflections to the particular text which had given rise to them. Figure 3.6 shows the reflective memo that was created for the memo attached to the circle (or node as NVivo describes them). This screenshot depicts the date and time along with the analyst's thoughts in this instance about validity, through the use of such a process:

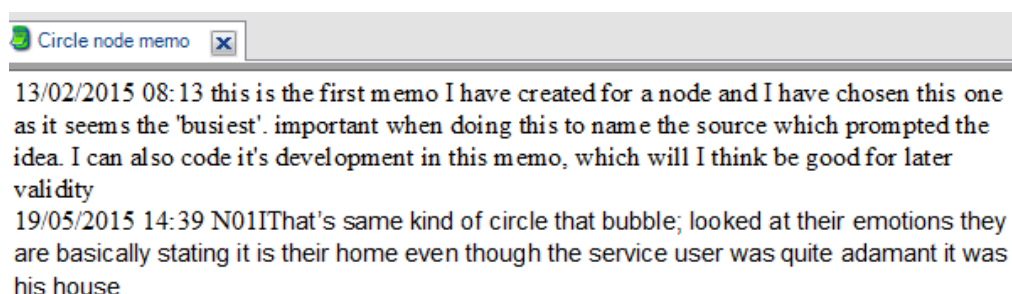


Figure 3.6 memo attached to a code.

Last, a reflective journal within the software package and relating to the process of data analysis as a whole was created. Figure 3.7 provides a screenshot of an extract of this journal wherein the researcher reflects on the possible advantages of using the software package as a way of enabling analysis. This learning process and the discussion of doing so *inside* the computer software package contributed to quality and validity of using interpretative phenomenological analysis in this thesis (Vicary et al., 2016).

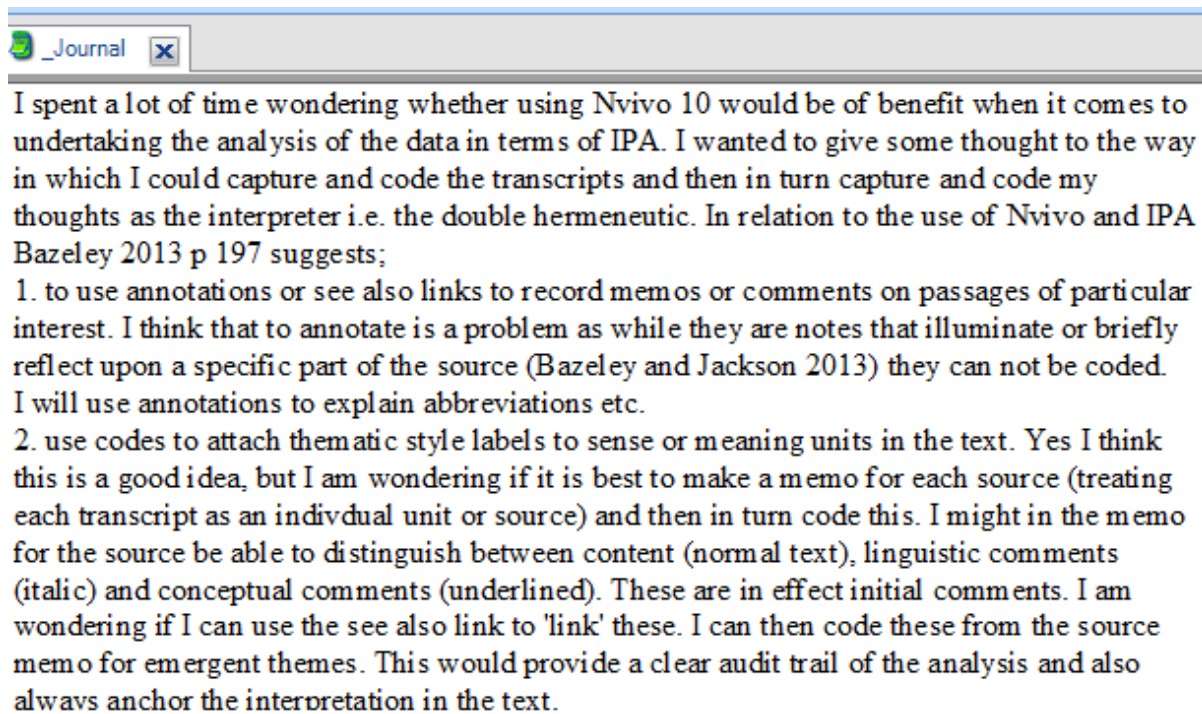


Figure 3.7 Excerpt from the researcher's reflective journal debating the use of the software package for IPA analysis.

The software package in effect afforded the opportunity not just for the reflective journal to be created and used throughout the process of analysis but excerpts of it were downloaded and provided to supervisors in order to enable discussions of the data analysis. In doing so, it became clear to the researcher and her supervisors that the use of a journal in this way, and especially the transparency it afforded, would also contribute to the quality and validity (Vicary et al., 2016). The next section of this chapter considers in more detail quality and validity as it is applied in this study, but first there is an explanation of the other software tools that were considered but ultimately not used in the analysis, with rationale.

It has been shown earlier that the use of memos anchored in the text can help provide a useful audit trail. The software package used in this analysis has other mechanisms to help manage data, including modelling and reporting. Modelling enables the user to provide a pictorial representation of codes as they refer to one participant and also

allows the analyst to move codes around to see possible connections between them. The following screenshot depicts the model that the researcher created for the first nurse participant in which the researcher started to change shape construction and grouped codes according to their understanding of the content of them. The figure shown appears static but can readily be moved on screen:

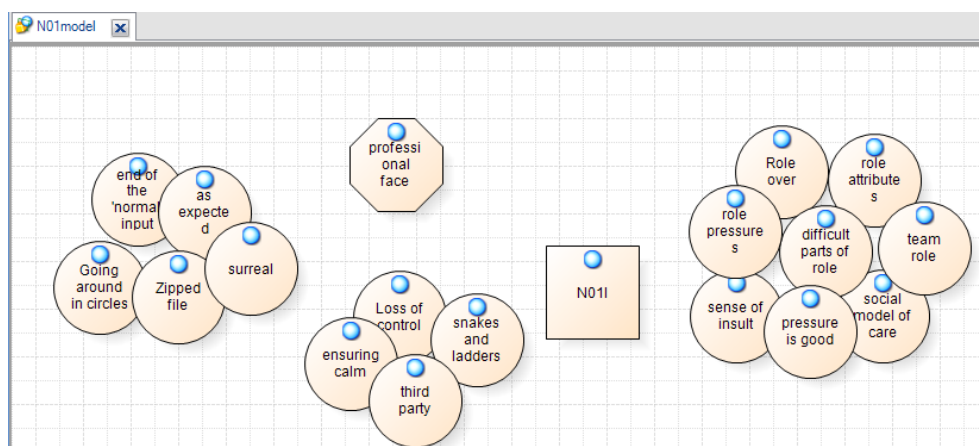


Figure 3.8 Screenshot depicting a model for one nurse participant.

The modelling function also allows codes to be moved around by the analyst as a way of combining them into possible themes. At first the researcher in this study was attracted by this as it seems to allow them to focus on the individual and also to compare and contrast models and therefore individuals.

The following screenshot depicts the model that was created for the first social work participant. Again this was not a final version; rather it was an aid to thinking about the codes and possible themes:

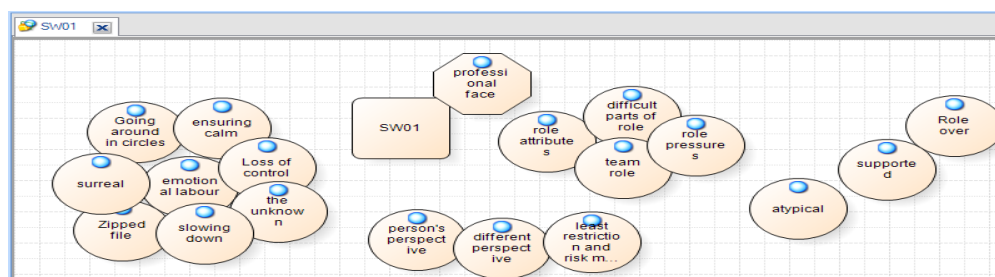


Figure 3.9 Screenshot of model for a social work participant.

The researcher was also able to create a report which, on exportation, provides the quotes in relation to each code by each participant. What follows is a screenshot (Figure 3.10) of the first page of a much longer (97 page) report but clearly laid out document showing in this instance an excerpt for the code ‘as expected’.

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number	Coded By Initials	Modified On
<b>Node</b>						
Nodes\\as expected						
Document						
Internals\\N011						
No		0.0347	12			
				1	SAOM3	01/10/2014 10:23
from the initial call to getting the logistics sorted and setting it up took twenty minutes/half an hour						
				2	SAOM3	01/10/2014 10:23
Everything's going great						
				3	SAOM3	01/10/2014 15:23
explored it a bit more looked at the issues the concerns the risk around this threat to dad						
				4	SAOM3	30/09/2014 11:27
we then obviously went						
				5	SAOM3	01/10/2014 15:43
Encompassed the full picture from the social right through to his mental health and his physical health. We looked at relationships within the family because again that seemed to be quite important for the family that that relationship was breaking down.						

Figure 3.10 Screenshot of a section of the full report depicting one code and related quotes.

Both modelling and the production of report at first appeared a good way for the researcher epistemologically and methodologically to ‘align’ upon a theme, but again this was of concern to them since its reliance on the codes only and perhaps on the powerful tools available, might result in taking the researcher away from the close

interpretation of the data. Moreover, the use of such mechanical tools could also mean a move towards quantifying (Stanley and Temple, 1995). Neither were ultimately used as tools in the analysis for these reasons. The researcher's initial concern was that the software package was imposing a structure on the data and might not allow them to focus on the content, but they became satisfied that they could 'pick and choose' its tools and do so from the point of view of the understanding of the methodology. Each script has been coded, a process that provides at best a possible theme but at worst list of 'anchorable' quotes under each code. Also the memo function allowed real-time recording of their reflective thoughts on the script of each participant and in turn on each code. In addition, where a theme had seemingly arisen, they have been able to code and link a memo to this and then imported notes of their reading of the theory which is arising as shown in the following screenshot (Figure 3.11):

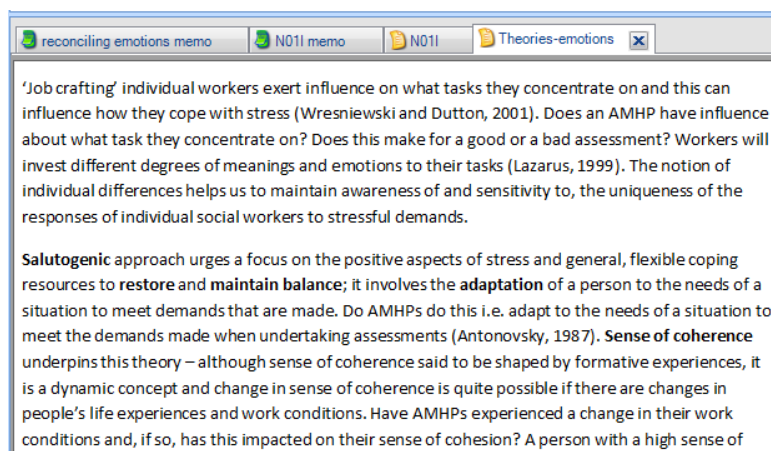


Figure 3.11 Screenshot depicting a code memo, a transcript memo, a transcript and theories.

The researcher concluded that whilst the use of tools within the computer software package does provide a structure, it is of the analytical process and not of the understanding or interpretation of the data. Their remaining concern was that the codes and memos are their own interpretations, but in IPA this is the rationale for the

analysis and this interpretation when anchored in the data is crucial to transparency and is part of quality and validity, to which this chapter now turns.

## **Quality and Validity**

The issue of quality and validity is pertinent to all research and numerous ways of measuring it have been suggested including early ones for naturalistic inquiry (Guba and Lincoln, 1982), psychology and related fields (Elliott et al., 1999), and those questioning rigour, integrity and artistry (Finlay, 2006). The criteria offered to measure quality and validity for IPA research in particular have been adapted from what was, at the time, a new way of considering such matters for qualitative research in psychology (Yardley, 2008). These measures involve four broad principles: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. Later, Smith undertook a review of papers that used IPA as their methodology and developed further criteria against which he judged was a good study (Smith, 2011a), work that began a debate about the future direction of IPA, including that of its quality and validity. These combination of measures are now applied in turn to this thesis using the same application as Smith et al. (2009, pp. 180-184) and also as these more recent updates have developed.

Sensitivity to context, according to Yardley (2008, p. 219), is that research must recognise and represent sound understandings in theory, show good knowledge of the relevant literature, as well as recognise the social and cultural setting, the perspective of the participant and all ethical issues. This chapter began with an explanation of the theory that underpins this research. The theory that underpins approved mental health practice is discussed in Chapter Two and also in the discussion of the findings in Chapter Five. In addition, the excerpts in Chapter Six, demonstrate real-time

consideration of theory as the analysis was progressing (Figure 6.1). The social and cultural setting of this thesis forms one of the critiques arising from the use of the methodology and is further discussed in Chapter Six. The presentation of the findings is shown from the perspective of the participant, but, as with all IPA studies the interpretation of the researcher is also important. Ethical issues are addressed earlier in this chapter.

Smith et al. (2009) applied the criterion of sensitivity to context in terms of the recruitment of participants who share a particular lived experience. They also contend that engagement with the gatekeeper can prove central to the viability of the study (Smith et al, 2009 p.180). As discussed earlier in this chapter, the role of the gatekeeper and the researcher's engagement with them was certainly of importance in accessing the sample for this thesis. Furthermore, sensitivity is also said to be shown by a good awareness and successful application of the interview process and includes showing empathy and putting the participant at ease (Smith et al., 2009 p.180). The researcher in this thesis is skilled in such matters, given their own professional background as a social worker, and was able to transfer these skills into the research interview being mindful of the different purpose, a matter that was explored during the ethical process and in conversations with supervisors. Smith et al. also contend that a strong study will always have a considerable number of verbatim extracts from the participants to support the arguments being made thereby giving voice and allowing interpretations to be checked by the reader (Smith et al., 2009 p.180). This thesis includes such quantity provided in support of the argument as shown in Chapter Four. Moreover, interpretations are presented as such and general claims made cautiously. Last, in terms of sensitivity, as in most studies, the relevant substantive literature is used to help orient the study and the

findings it is argued should be related to relevant literature in the discussion (Smith et al, 2009 p.181), as shown in Chapters Two and Five.

Moving on to the second criterion, commitment and rigour, Yardley (2008) describes this as the requirement for in-depth engagement with the topic, and methodological competence as demonstrated through data generation and the depth and breadth of the analysis. Attentiveness to the participant during the data collection and the care in which the analysis of each case is carried out is said to meet this criterion, according to IPA's progenitor (Smith et al., 2009 p.181). As has been described, each interview was audio-recorded. An outsider would be able to judge attentiveness to the participant during the interview should there be doubt. This can also be found in the transcript. Again, the researcher undertook this transcription herself but this can be checked if doubted. In addition, what is shown is a movement beyond the descriptive to interpretation and this is further demonstrated in the presentation of the findings. Each theme is supported with quotes from a number of participants in Chapter Four and are drawn on in the overall discussion in Chapter Five, thereby enabling the reader to understand where the interpretation has arisen and also agree or disagree. An example of the way in which this process was conducted in this study is available in Figure 6.1 Chapter Six.

The third principle is transparency and coherence. For Yardley (2008, p. 219) this criterion means clarity and power of the description and argument, that the methods are transparent and that there is a fit between this and the presentation of the data. Last, the researcher must show reflexivity. In this thesis, evidenced is provided as to how each participant was selected, how the interview schedule was constructed including the request to draw a Rich Picture and how the interview was conducted. The writing and redrafting of the analysis has been an iterative process that has made the analysis clearer. The degree of fit between the underlying theoretical assumptions of the research



has been discussed and is consistent with the underlying principles of IPA including interpretation and idiography. The write up has as its focus on significant experiential domains, see, for example, in the analysis section “pull” (Chapter Four pages 157-167). Last, the researcher has shown reflexivity. This is encapsulated in the examples provided in the conclusion to the thesis which also enact the double hermeneutic, bracketing, or adopting the phenomenological attitude.

In the last criterion presented by Yardley, research is judged by its impact and importance on theory, social and cultural aspects along with practicality for policy makers and [health] workers. The findings from this study and their possible impact are discussed in detail in the conclusion to this thesis (Chapter Six).

### **Conclusion to the chapter**

IPA is a relatively new qualitative methodology that is little used in the qualitative social work research tradition. This chapter has argued that both the purpose and practicalities of this research study fit most readily with this methodology. From an ontological perspective, IPA focuses on subjective reality from the viewpoint of the participant. This research study wishes to explore the reality of undertaking compulsory mental health assessments from the viewpoint of the designated professionals.

Furthermore, for IPA, knowledge arises from the meaning the participant makes of their experience, or reality. This methodology encourages the acquisition of knowledge through meaning making, by the participant and by the researcher. The critique of IPA highlights a possible flaw; that of not positioning psychological experience in social context. As has been seen such developments are welcomed by IPA apologists and are not perceived as a barrier to the use of IPA for this research study. Increasingly used in wider subject areas and by other research disciplines, IPA is also suited to qualitative

research in social work, the tradition employed in this research study. Based in an interpretive paradigm, IPA draws upon a range of influences which drive the methodology. These influences, adopting the phenomenological attitude, engaging in the hermeneutic circle, and focussing on a particular phenomenon match well both with the role of the researcher and the dynamics of the research. It is, therefore, also practically suited.

The techniques and processes adopted in this study have been outlined including those relating to seeking ethical permission and of access to participants, with rationale for the makeup and size of the sample. In addition, the process for generating of data and the analysis thereof is also explained. One method used to gather data was that of a semi-structured interview and is well known to qualitative research approaches, including IPA. The other, the drawing of a Rich Picture carried out immediately prior to the interview and discussed as one part of it, is less well known. Whilst both were used to elicit detailed data, the transcription arising from the first provided the data for analysis and the drawings from the second have been used for illustrative purposes only. Data have been managed using a computer software package and the tools that were chosen outlined along with an explanation of those that were not used with reason. The chapter concludes with a discussion of quality and validity as it applies in this study using the applied criteria common to IPA and as it is currently being developed. Overall, the best methodological fit for this thesis is IPA and the research design has been accomplished accordingly.

## **CHAPTER FOUR**

### **Presentation of Findings**

#### **Introduction to the chapter**

This chapter presents the findings that have arisen as a result of the analysis and is divided into six main themes as follows:

- Being determined and undetermined.
- Abandonment and sabotage.
- Praxis.
- “Pull:” the active use of dissonance.
- From “unclean” to “honorary social workers.”
- “Popping someone’s bubble.”

Each theme is introduced and summarised. Evidence is provided through verbatim quotes from a range of participants as identified by the acronyms outlined in Chapter Three, for example the first social work participant is referred to with the initials SW and 01. Quotes are signified either by indented, italicised text or by the use of quotations marks where they appear in the main text. Rich Pictures, either full or in part, are included where appropriate to illustrate themes. To begin, details of the sample are outlined.

#### **The sample**

The participant sample for this thesis comprised five social workers (three male and two female), five nurses (three female and two male) and two occupational therapists (both female). Professional background, gender and longevity are shown in more detail in Appendix Four.

## **Being determined and undetermined**

### *Introduction*

In this first section of the analysis participants describe their role as one of contradiction and ambiguity. It is simultaneously experienced as straightforward, yet complex, one that creates discomfort in others and is experienced as such by themselves but also one to which they bring balance of the various aspects involved. There is a flow underlying the role which demonstrates the capacity to hold and use disparate elements.

### *A straightforward, yet complex role*

Approved mental health practice is a formal, legal process which takes participants out of ordinary day to day practice; a common experience as described by one nurse participant:

*Swear an oath on the Bible, that sort of thing, something we are not used to in day to day practice, something that made you sort of realise the formality of what we were doing. (Nurse 02)*

A social work participant attempts to describe approved mental health practice “in a nutshell” suggesting by this that the role and description of it is uncomplicated.

Approved mental health practitioners undertake a linear procedural process which opens with the taking of a referral or request. The next step is to make a decision as to whether what is being asked is a correct request or “ours”:

*My role is to take referrals, to fill out the referral form, to decide whether it's ours or .....to, to decide what needs to be done, to see whether it is an AMPH assessment. (Social Worker 05)*

If the request is deemed “ours” the process then involves coordination of the people who may also be required in order for it to go ahead, and of information gathering. The aim is to find out as much about the person being referred in order to have a connection or “make a link” with that person. At this stage participants are using assessment refers to the whole process:

*Or, make that, you know, make that decision whether it's appropriate or not erm, you know, coordinate speak to people, gather information try and get to know as much as you can about the person, gather all the information you need, try and make a decision about what you are going to do based on all the information you've got, try and get that link with the person. (Social Worker 05)*

This build-up of the process, or assessment, continues and includes, as well as ascertaining the wishes of the person, ascertaining those of any significant parties, in particular the identification and views of a legally identified person and safeguard, the Nearest Relative. This stage of the assessment process remains pre-interview, before you get to “that point”:

*'Is there anything else that should have been done before you get to that point? [the interview], you know erm you're looking at getting the person's views and the wishes and feelings, getting their family's wishes and feelings you, you've got the Nearest Relative to consider, and who is the Nearest Relative. (Social Worker 05)*

In addition, approved mental health practitioners have to establish whether there will be any practical matters to enable the interview stage of the assessment to be carried out such as, in this instance, access to language interpreters:

*I can't you know it would take me more than half an hour you know to talk you through, you know, the things that we need to do you know. We work with interpreters, you know, we, this might be a person from a different culture and then this is going to be doing, this link is going to be all the more difficult because I don't speak the language. So then it is interpreter services and trying to do the best that you can and trying to think about that in relation to their culture. (Social Worker 05)*

Once the process gets to “that point”, as several participants describe it, the role again involves coordination; of the person, any relatives and of the other professionals as one nurse participant describes:

*He [the person subject to the assessment] actually he let the police in and again outside the property there was a really uncomfortable situation to be in because there was myself, my colleague, there was the police there, there was the doctor there, there was the son there and we are on quite an enclosed street with neighbours looking on. (Nurse 02)*

This same participant recalls a second occasion when she was coordinating the situation. Here she conflates the assessment and the interview:

*The lady did actually invite us all in which in some ways well I thought has she got any choice because all of these people are stood outside on the street*

*drawing attention to me so felt very uncomfortable but she did invite us in, so we were in the house erm the assessment [interview] was conducted. (Nurse 02)*

Protecting the person subject to the assessment from public gaze is a repeated feature and illustrated by another nurse participant (Nurse 04) in an excerpt from their drawing:

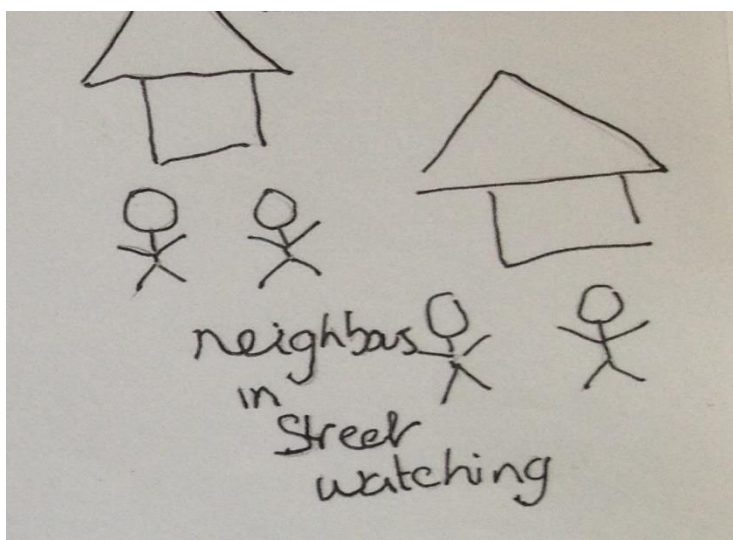


Figure 4.1 Excerpt of a Rich Picture depicting the neighbours watching.

If a decision to apply for detention to hospital is made, approved mental health practitioners have a remaining number of tasks which again involves coordination; on this occasion, how the person gets to hospital:

*We were waiting in the house for the ambulance to arrive which again obviously an ongoing issue at the moment. I think it was only a two hour wait which by today's standards that's not too long erm and then everything sort of worked quite well after that she erm she was transported by ambulance to hospital erm and at hospital the papers were accepted by the ward and the lady was familiar with the ward, the staff were familiar with her from previous admissions and everything was quite straightforward from that point of view. (Social Worker 05)*

This is followed by the write up of required notes as described by one social work participant:

*That's me, that's the statutory report coming out of a typewriter. (Social Worker 02)*

He also illustrates this in his picture with a snake-like representation of its length:



Figure 4.2 Excerpt of a Rich Picture depicting report writing.

Approved mental health practice, then, at first involves seemingly straightforward, if considerable work, a lot of which occurs before the person subject to the assessment is actually interviewed.

However, despite on one level such straight forward description focus on step-wise process, the analysis also shows that the participants recognise a more complex role too which has many layers and which is not always carried out in a linear sequence:

*You don't necessarily do anything in a perfect sequence but there are natural kind of points to kind pause and think about this is you know the point of referral there is a key decision being made there. That is the time to take stock of what is being decided there. You know when you are gathering new information there are a number of things going on there. (Social Worker 02)*



By way of contrast to the “nutshell”, participants describe a complex picture; one that includes various aspects in addition to the legal ones:

*It's, it's a complex picture isn't it, of lots of different balancing things you've got to realise when you need legal advice, when do you need that legal support, when do I pick up the 'phone and 'phone legal. Is it ok for me to get the Jones out [manual used to check the interpretation of the law] and look at the Code of Practice? Or, do I actually need to consult the legal team, erm, do we need to go to Court, have we got Nearest Relative displacement to undertake? Er, there's just there's so many different aspects of the role. (Social Worker 05)*

On occasion the complexity becomes heightened, such as when obtaining warrants for admission to someone's house whilst, in addition, having to advise police colleagues as to their proper execution:

*The issue of trying to remember the, how a warrant should be executed erm and the order of things so, and the police not really understanding, having to explain to the police that its them that actually executes the warrant erm so we sort of, we managed to do that. (Nurse 02)*

Juggling different components is revealed as a constant feature of the assessment process and is depicted as such by another social work participant in which she draws herself with many arms dealing simultaneously with the various elements (Social Worker 05):

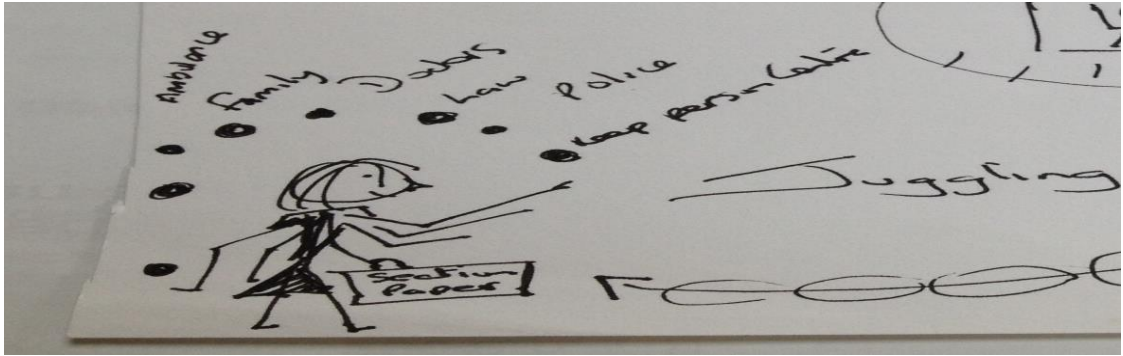


Figure 4.3: Excerpt of a Rich Picture depicting juggling (Matthews, 2013 p.15).

These multi-layered aspects associated with preparing for the interview itself include “making that link” but as one social work participant contends, they can also “pre-occupy” (Social Worker 04):

*Another layer and another delay that you need to fit in with courts before you can even go and see the individual and Jones is to represent, well there’s usually the legal issue particularly around the Nearest Relative. (Social Worker 04)*

Throughout the assessment process “making a link” with the person is key albeit the actual interview is sometimes viewed as the easy part, as the same social work participant describes:

*So this is actually meant to be the service user sometimes it happens and I see this with other AMHPs in supervision that we, you know, all these other considerations are preoccupying you and actually that service user get pushed to the side and in fact they are the easiest bit of it, the interview. (Social Worker 04)*

He acknowledges this irony by placing the service user in the corner of his picture:

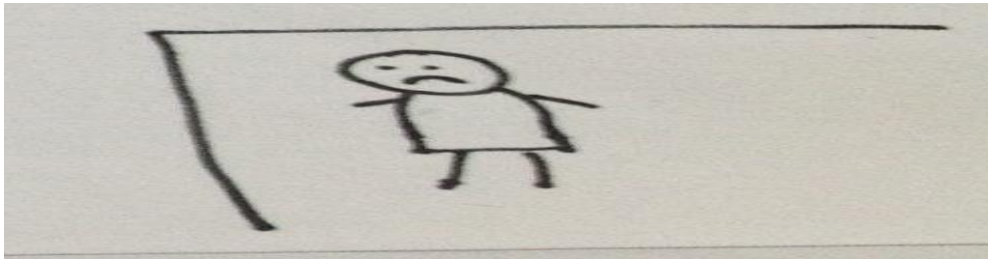


Figure 4.4 Excerpt of a Rich Picture depicting service user in the corner.

A nurse participant (Nurse 02) depicts an assessment and the build-up to the interview, elements of which include telephone calls, speaking with and coordinating others and being time pressured:

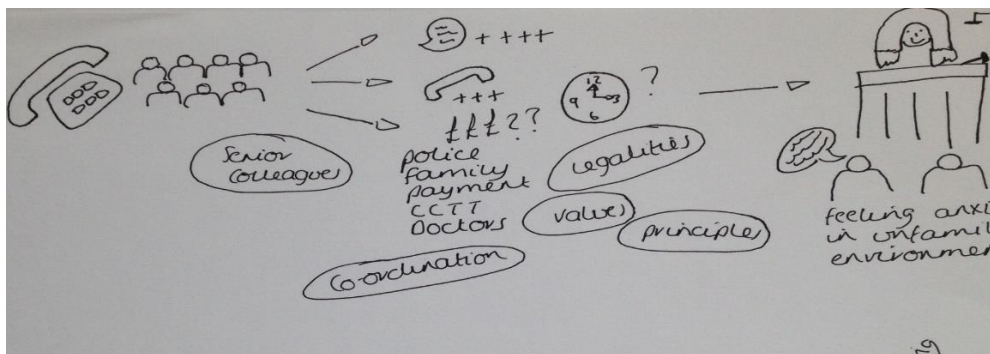


Figure 4.5: Excerpt of a Rich Picture depicting various pre-interview tasks.

But the tasks involved in the assessment process are not always regarded as distinct and also become conflated, not least between the assessment as a whole, and the interview as one part of that assessment, thereby encapsulating both its straightforwardness and its complexity. One social work participant does exactly this whilst at the same time pointing it out:

*Some of it is about planning for the logistics of the actual assessment, but some of it is about analysing and bringing people into the assessment you know that is a discrete thing. I suppose for me one of the things I found lacking in some of the*

*literature erm is, is the conflation of the assessment with the interview. (Social Worker 02)*

### ***A role of discomfort and balance***

Engendering or being subjected to discomfort whilst achieving balance are also deep-seated features reported by participants. Being prepared not simply to follow the procedures or not sign the pink form, (the forms which are used in the application process), is at its core:

*There is often that kind of thinking. You know, all we want to do is we get this person, call them in and they sign this pink form and that's it and that's what they do, it's a bureaucratic thing and that's what they do. (Social Worker 01)*

Approved mental health practitioners have to be convinced that admission to hospital is needed and, if they think this is not the case, they must be prepared “not to sign” the legal application for detention:

*I am prepared to not sign, I mean not, it's usually not quite like that it's usually I am just holding on to that bit in the Code of Practice which talks about how one keeps the patient at the centre of things and that you know we need to have a conversation about the disagreement. I am uncomfortable about this and I feel as though I might take you know that I need you to convince me. (Social Worker 01)*

Participants feel that the interview stage should be carried out in as appropriate manner as it can be for the person subject to the assessment using listening skills and understanding. Even so, the outcome may not be as that person would wish and is therefore uncomfortable for the person being assessed:

*I will give someone an experience that I have really tried to listen and try to understand things. I'm not sure how successful I am from their point of view, but I'm not necessarily going to agree [with the person subject to the assessment].*  
(Social Worker 01)

Making things uncomfortable applies to other professionals as well as to the person subject to the assessment. This same social work participant prefers a disagreement with others to what he feels might be the alternative of ending up in a coroner's court:

*I'd rather he [the doctor] be cross with me now than meeting me at the coroner's court. (Social Worker 01)*

Such pragmatism also means the discomfort for the approved mental health practitioner in making a decision which might ultimately not be the right one:

*I think the other thing is accepting that there often isn't an absolute right or an absolute wrong that there's doing the best you can having, providing you've made, really thought about it and erm weighed it up and you know why you are doing, why you have made the decision you have, you know, it may prove not to be right. (Social Worker 01)*

Asking questions, slowing the process down and perhaps disagreeing with the judgement which has been already made by others is, for this same social work participant, crucial:

*And erm, and actually when I start asking questions, you can see people, sometimes they are a bit irritated. He's going to make this difficult. You know I might have said, why now, if we go around now do we have a plan. Is this going to make things worse? We might only have one shot of it because we might lose*

*the person, whatever the scenario is. It is something about weighing up, because I think part of my role is helping people think around. They've often made the decision you know x needs to be in hospital. (Social Worker 01)*

The perception that approved mental health practice is a weighty legal role also manifests itself in discomfort for participants; here it concerns the fear of litigation. This possible consequence is, for one social work participant, indicative of the complexity of the role which goes beyond a simple understanding of the law and a reason why undertaking it does not suit everyone:

*I think a lot of people want to do it at first they don't really know what it's about, oh I can learn the law, I can do that, I already know that actually because I've done a lot of backup but then when you're it. I think a lot of people find backup duty interesting and fun but they are just observing and sat there, you know we I give them things to do but you're not they're not the one that's going to be dragged through the courts kicking and screaming if anything goes wrong. (Social Worker 03)*

For her the role or “the real thing” is a different matter, even to the extent that she has seen it have a physiological impact on people new to it:

*And when they then become AMHPs they, their eyes change they got a facial expression that's like, it's different isn't it, it's not like when you are on backup. Erm so yes I mean I think, yeah there's a real thing. (Social Worker 03)*

Another social work participant fears the consequences for himself:

*I mean I suppose I have this kind of an underlying fear of how serious the consequences are for me could be if it goes wrong. (Social Worker 02)*

He illustrates this in his drawing of what he describes as an AMHP prison in which he is locked:

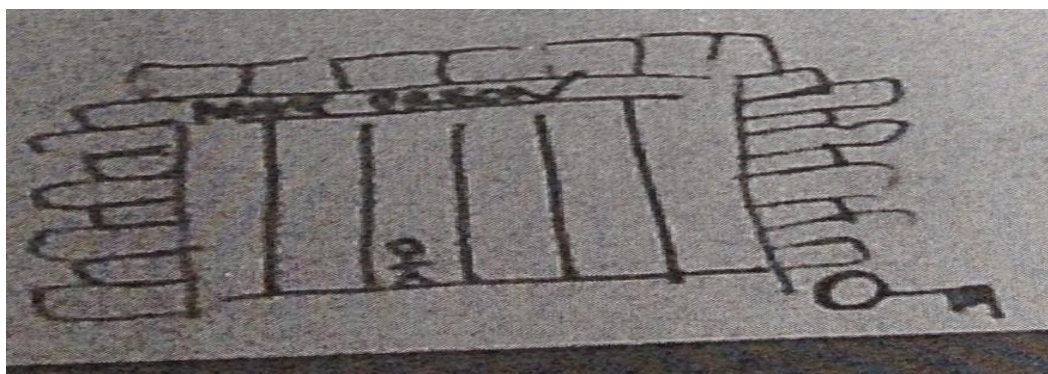


Figure 4.6 Excerpt of a Rich Picture depicting an AMHP prison.

Balancing is also identified as an aspect of the role and involves reflection as to whether those tasks being undertaken at any one time are weighted correctly. According to a nurse participant, elements include being mindful of clinical practice, having the ability to coordinate and to manage, and to have knowledge as to what legal requirements apply:

*I was permanently questioning whether I was doing the right thing and it was getting the balance right between your clinical practice, your coordination and management skills, your legal knowledge. (Nurse 02)*

Balancing different elements such as contacting people usually by telephone, finding out if a hospital bed is available, being prepared to deal with any pets or other animals and obtaining warrants if needed, is depicted in a drawing by a social work participant (Social Worker 04). Note again the multiplicity of tasks and subjects that are all depicted as

revolving around the approved mental health practitioner, similar to the juggling picture of the other participant:

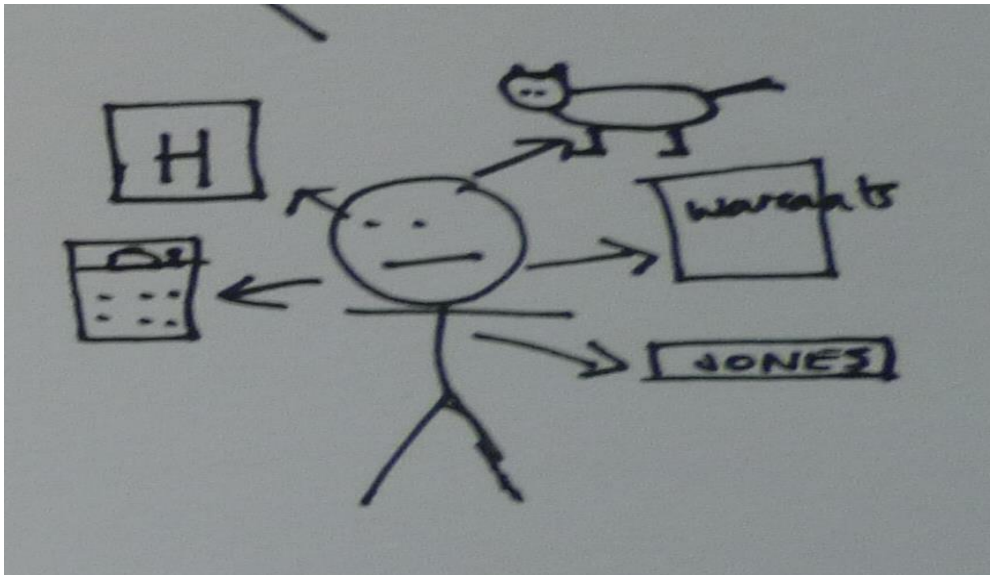


Figure 4.7 Excerpt of a Rich Picture depicting multiplicity of tasks. (Matthews, 2013 p.17).

Furthermore, balancing the best interests of person against those of others is encapsulated in a metaphor of a weighing scale by one social work participant:

*I've got scales. So what I am trying to do as I'm trying to balance the best interest of the person and I'm trying to balance safety and risks and health of this man in his house with this crumbling system that I've got around me and try to juggle at the same time. (Social Worker 05)*

She illustrates this in her picture:



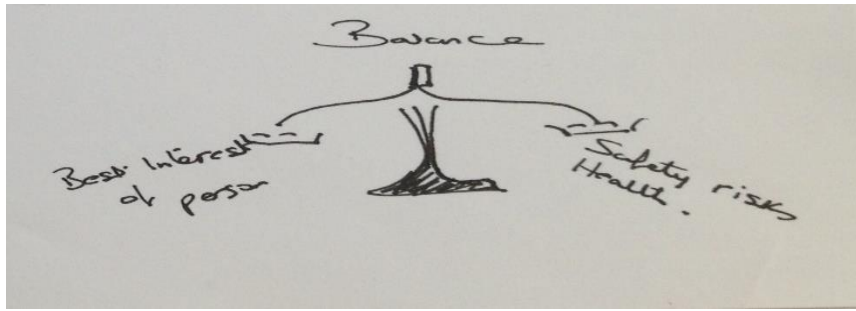


Figure 4.8 Excerpt of a Rich Picture depicting balance. (Matthews, 2013 p.14)

It is perhaps undeliberate and unintended that the type of scales she draws have visual echoes of the famous scales of justice statue above the Old Bailey that has become a generalised metaphor for justice in the British system.

### ***A role of giving, taking and “smoothing”***

As has been seen, the participants in this analysis deem that, to begin, they have to decide if the referral for assessment is “ours”. If deemed not, then participants report that their role is to advise the person making the referral to find out more. In effect participants are advising the referee to stop what they are doing and instead undertake their own role more fully:

*To say no, go away, go out and see that person, what are you come to me for, you haven't seen them for two weeks, go and knock on the door you know, don't come to me go away. (Nurse 03)*

Other aspects, first reported in participants' descriptions of the build-up of the assessment, repeat at interview; one of which is coordination. However, the meaning of coordination here is not the “straightforward” organisation of people and information, it is also about managing the emotions of others. One social work participant describes having to deal with everyone's impatience, as well as the distress of the person subject

to the assessment and that of any relatives. He also feels he has to deal with the emotions of other professionals such as the police and the ambulance services. He uses the concept emotional labour to encapsulate this:

*You know, everybody's getting impatient. You've potentially got erm, you know, a patient in distress. You might have got a relative in distress, the police and the ambulance and whoever is there. And, kind of, you know and it's that erm emotional labour again. (Social Worker 02)*

He repeats his perception of the role as having to contain and manage the actual physical circumstances as well as the psychological emotions the situation is evoking in others:

*The fact that what you are kind of doing is, you have to manage other people's emotions in there. You know that, that maybe there isn't anything you can do, but what you can do is to try and contain the situation, contain the emotions so that it is at least tolerable or as tolerable as it can be erm for the distressed parties. (Social Worker 02)*

Similarly, a nurse participant speaks of being a conduit and, ultimately, a repository for others' anxiety:

*I think AMHPs become a conduit for people's anxiety I don't think people are bothered with what you do with it, they are not bothered in the slightest what you do they just want to pass their anxiety over. (Nurse 03)*

Moreover, this same nurse participant feels that the role is to take on the risk which he feels other professionals are not willing to do, for fear of being chastised or not 'doing the right thing'. He views this as a significant burden:

*A lot of it is about the professional not wanting to be chastised for any errors in their practice and the risk aversion the people not want to lose their jobs essentially and I think that's a massive, a massive burden on the AMHP role.*

*(Nurse 03)*

Albeit, according to this participant, this burden can be “given back”. For him, the role involves making a decision about what is, and what is not, expected work and to enable those who make inappropriate referrals to take back responsibility. First, this handing back of work judged as not fitting, is done in a supportive and supervisory manner:

*The professional who is in tears because they are anxious and they don't know where to go. I think a lot of it is they make a call to the AMHP for help and it's more about I don't know what to do with it so please take my anxieties here it's over to you know, you get on with it you do it, you do it, I don't know what to do, you do it and it's about, a lot of it's a supervisory role, it's supervising; well, have you tried this? (Nurse 03)*

Second, giving back also indicates power in the role which, nevertheless, is carried out in a skilled way:

*I think that's a huge part of the AMHP role. Is taking that containing it and giving it back to the person whereby if it's not appropriate to proceed with a full mental health act assessment then its powerful, powerful mechanism. It's how you pass that back to the professional really. (Nurse 03)*

These inappropriate referrals, according to this same nurse participant, seem to be occurring more regularly and as a direct result of difficulties being experienced in other parts of services:

*There was five [requests for assessments] the other day. If you broke it down, if you looked at it kind of, you know, objectively, you would question whether any of them were Mental Health Act assessments. They just want the problem to go away. That's my feeling. (Nurse 03)*

Losing one's job and fear of litigation is again at the forefront. A nurse participant equates the financial pressures facing wider services and resulting defensive practice now means, for him, that others attempt to use approved mental health practitioners to deal with such risk:

*I think people think because they are making reductions everywhere people think they are disposable so I think if they make any slight error questions will be asked therefore they'll be sacked or asked to leave or whatever. Nobody wants to go through coroners and all that carry on, so they give it to someone else. (Nurse 03)*

A minority of participants report positive risk taking or "smoothing", the meaning of which is to give the alternatives (to hospital admission) due consideration:

*One can be looking at alternatives and admission as a last resort and exploring all other options, even if there are risks attached to that. Obviously positive risk taking, managing that risk, but there is smoothing there has to be - giving the alternatives a chance before a decision is made to admit somebody. (Nurse 03)*

However, a hospital bed has to be sought and the approved mental health practitioner, even though this is neither their determined or expected responsibility can feel obliged to pursue this:

*The responsibility you know ordinarily lies with the consultant in finding beds for people however that seems to have been a local agreement which falls down to the AMHP requesting the beds from the local bed finders. (Nurse 01)*

And, even once obtained, the bed still sometimes “falls through” as this participant termed it:

*It's when you are kind of relying on well you know, all of a sudden the bed has fallen through well I understood there to be a bed so how are we going to get a bed we, you know it sometimes kind of thinking about this whole process we are looking about respect ...I mean we don't usually have to have a fight with the doctors about whose responsibility it is they are very clear. In fact they should be in fact they should be. It isn't the business of the local authority or an AMHP to be erm finding bed space for a patient. (Social Worker 02)*

There is also a consequence when not finding a bed happens, not least that an approved mental health practitioner is unable to complete the assessment process and, as a consequence, also unable to undertake any other work:

*Why is it falling on to social workers, you know AMHPs, to put up with that, to be restricted from them doing their job, from say them being able to do another assessment that day. You know if you are there being held up for four or five hours 'cause there's no identified bed, you are struggling to make an application. (Nurse 01)*

This lack of a bed also leaves approved mental health practitioners in a difficult situation as they have to stay with the person now liable for detention until they can arrange transport to hospital. At the same time, that person might leave:

*So, you are in a Catch 22 this person you know could leave at any time alright they are liable to be detained but you are feeling at that moment that it's an iffy situation that you are left with. (Nurse 01)*

It also indicates that the situation contains paradox. On the one hand approved mental health practitioners are awaiting others whilst, on the other, nothing can go ahead without their say so:

*And they have no idea of your worries, about have you got the right Nearest Relative or not, you know, that you've got to rehome the cat that you are waiting for a hospital bed, you can't write your application until that's happened. You get the police trying to gee you on they are wanting to leave. (Social Worker 04)*

Locating alternatives where none exist compounds the lack of availability of beds. Participants in this analysis view themselves as dealing with other service driven matters outside of their control. Dealing with wider systems and in particular the frustration they experience in not having any influence over their allocation, is another aspect of the role. In this instance a social work participant expresses frustration with colleagues in Accident and Emergency Department who appear to believe that he has more influence on accessing a service than they actually do:

*I think A and E they are anxious to get rid of you and you think you know much more than me and you might able to do something to move this along you know you want us out of here I mean what sway have I got over the ambulance service or whatever else. (Social Worker 02)*

He is also dismayed that the staff in the department do not seem as bothered by the fact that a vulnerable person is seemingly languishing in an inappropriate facility:

*I'm sat here you know this is a guy with dementia who thankfully is blissfully unaware where he is seems to be able to be distracted, but five and a half hours later and we are talking about a specific assessment here and I'm thinking, "never mind why I am still here. Why is he still here?" You know this isn't right.*

*(Social Worker 02)*

The ultimate expression of such frustration is depicted in the drawing of a crumbling wall, each brick of which represents for the participant (Social Worker 05) the welfare state and its disintegration:

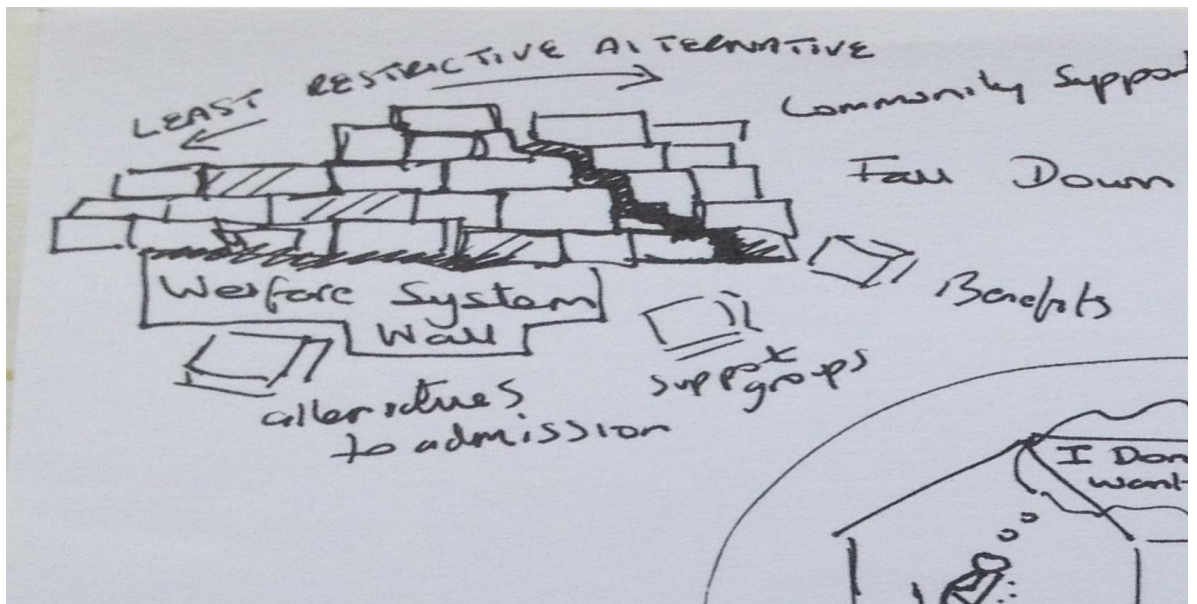


Figure 4.9: excerpt from Rich Picture depicting the disintegration of the welfare state.

### *Summary*

All participants in this section of the data analysis, irrespective of their professional background, gender or longevity determine approved mental health practice as a formal, legal process with set procedures. It is, nonetheless, experienced as undetermined, being at the same time straightforward yet complex. This indistinctness is embodied in

participants' conflation of interview with assessment, using the same term, 'assessment,' to refer to both. Throughout the enactment of their role participants reveal a desire to achieve balance even as discomfort to themselves and others is caused. This analysis also illustrates that participants are motivated to 'do the right thing', to control situations and the emotions invoked, whilst additionally 'giving back' any that are deemed inappropriate. This give-and-take is undertaken in a supportive, supervisory, yet assertive way and occurs when others are judged as 'not doing the right thing.'

Consideration of an alternative to detention or, not signing the pink form, is core yet participants also report an obligation to locate a hospital bed despite this not being determined in procedures; a seemingly discordant position. Participants view the former as positive risk taking, or "smoothing," which is a juxtaposition as the latter, locating a bed, could also be considered "smoothing". Participants also report an aspiration to use wider public services but, in reality, have little control over the provision or allocation of these; a last indeterminate in this analysis.

### **Abandonment and sabotage**

#### *Introduction*

Abandonment and sabotage are two themes which repeat in the data. Signified by the phrase "role over", participants are on occasion left to complete the assessment despite the physical situation which pertain. However, what also emerges in the data here is a challenge by participants to this sabotage and growing signs that roles as traditionally defined in psychiatry are being redefined.



### ***“Role over”***

A nurse participant refers to the doctors “doing their bit” and then leaving, none of which is a surprise to him:

*we discussed at that time that it was going to be section 2 [of the Mental Health Act] so what I’ve got there then is kind of the doctors then did their bit and left, which they tend to do. (Nurse 01)*

He goes on to refer to this occurrence as the equivalence of the doctor’s role being over, albeit he questions this:

*I’ve put role over question mark because for me it seems to be that once that decisions made it is, we can now go we can leave that situation. The AMHP’s left with it with whoever else is left sometimes you know you are left with the service user. (Nurse 01)*

He also depicts this in his picture:

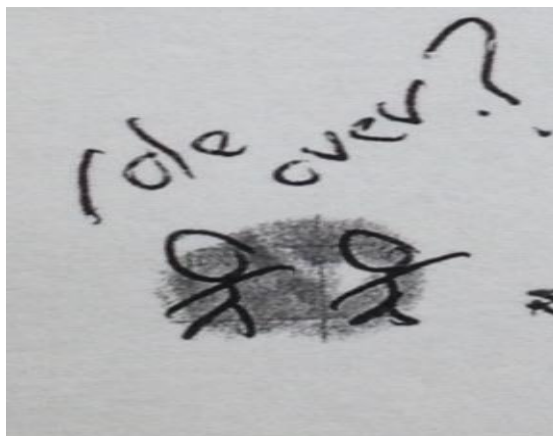


Figure 4.10. Excerpt of a Rich Picture depicting role over. (Vicary et al., 2016, p. 9.)

The questioning of this behaviour by doctors continues and, while this participant acknowledges respect for his medical colleagues, he is actually dissatisfied. Instead, he

contends that such an attitude shows a lack of involvement in the process and a poor sense of responsibility on the doctor's part:

*It's role over for them. Respectfully, they've been part of that overall application, the AMHP makes the application but they've had to make that recommendation before we can do anything with that. But that for me just seems to be, that's been it from day dot even when I remember kind of going back years. When we did it in AOT [Assertive Outreach Team] that would be it, end of. Yes, I mean rarely with the specialist assertive outreach you might get the consultant hanging around for a while, sometimes but more often than not they go so, I wouldn't say they, what I'd say is that I think there should be a bit more of a responsibility to actually feed more into the process with them, the reassuring side of things. If there is family around, you know support for colleagues you know stuff like that I don't think we'll ever get that far but that's just my feeling. (Nurse 01)*

Being left at this point during the assessment is also viewed as not unusual by an occupational therapist:

*The consultant had left, because often what we [AMHPs] do is we do the assessment, this is fairly typical. (Occupational Therapist 02)*

This is also depicted in a portion of her picture. It is interesting to note the smiling face:

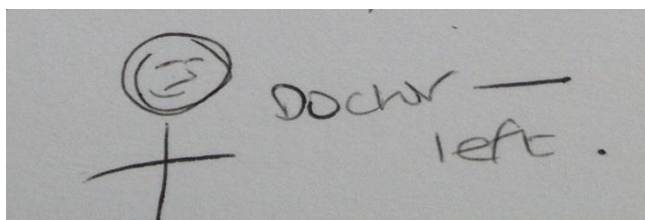


Figure 4.11 Excerpt of a Rich Picture depicting doctor leaving.

A social work participant too describes being left alone by doctors, especially once the payment to which the doctor is entitled has been authorised. He also illustrates this in a portion of his picture which depicts the doctors as male and formal:



Figure 4.12 Excerpt of a Rich Picture showing doctors leaving. (Matthews, 2013, p.13.)

*And this is to depict two doctors who just leave they you know sometimes they are eligible for a payment and off they go so you're kind of left on your own.*

*(Social Worker 4)*

This participant reaffirms that being left to carry on the assessment by the doctor means he then has to look to others to try and get support or, as he describes in more desperate terms, to “cling on”:

*....trying get support from partner agencies er and you are trying to hang on to cling on to that support. (Social Worker 04)*

This participant expresses his dissatisfaction that most doctors abandon colleagues in this way and explains this by saying it's because they lack understanding or compassion:

*Erm and, and you know most doctors actually with the exception of one that I can think of really have very little empathy or understanding of what's going on for you. (Social Worker 04)*

The flippant manner in which the abandonment takes place is also reported:

*They just go, "oh see you later goodbye." (Social Worker 04)*

A second social worker participant also refers to doctors abandoning the process in a similarly flippant manner:

*Well, I think being a coordinator in a way and I think you know doctors have usually buggered off at that point. (Social Worker 02)*

But, the seriousness of the situation and the coordination he is left to do alone is nonetheless clear:

*You know everybody's getting impatient you've potentially got erm you know a patient in distress you might have got a relative in distress the police and the ambulance and whoever is there. (Social Worker 02)*

The issue of the doctor leaving once payment had been authorised repeats. A dialogue between a nurse participant and the interviewer again indicates that doctors leaving during the assessment is the norm. The participant, whilst trying to be fair to the doctor, also points out that the person being assessed might have benefitted if the doctor had not left:

*One of them wanted his payment for signing. In all honesty erm the consultant was in and out. To be fair, he knew her, he made the decision that she needed to*

*be in hospital erm but he probably could have given her a little bit more time than he did.*

**Interviewer:** *And did you feel that you were left with the situation then?*

**Participant:** *Yeah, as always.* (Nurse 02)

Other elements of the assessment process, here obtaining a bed, are also given over to participants. One nurse refers to this as “the art of delegation”:

*Interviewer*

*So I thought it was the consultant’s duty to get the bed*

*Respondent*

*No, well they delegate. They delegate to us, the art of delegation*

*(Nurse 05)*

But, on this occasion, the doctor abandoned the assessment even before it had begun. Despite this nurse participant speaking positively about the good relationship she has with the doctors in her team, the assessment did not go ahead as planned. The doctor, in effect sabotages the assessment and for reasons personal to him; “he preferred to go home”. The participant does attempt to justify this. She otherwise views this colleague as “conscientious” and “supportive”, neither a “God” nor an “angel”. Nonetheless, she was left having to rearrange the assessment and with an underlying sense of dissatisfaction:

*Because it was four o’clock, it was four o’clock. Like I say our consultants here are brilliant I’ve known them go out at five to five. They are not God they are not angels but they are very conscientious and very, very supportive. So I’ve*

*known them go out at five o'clock to help an AMHP in the community not me ...because they don't want them out there they want everything sorted as quick as possible. To get the best outcome, but he preferred to go home. (Nurse 05)*

Her description of another assessment had exactly the same initial response. The assessment process halts because the doctor could not attend. Whilst it is not clear on this occasion the reason why, especially so late into the arrangements having been made, this nonetheless is further evidence of sabotage on a doctor's part:

*initially it went wrong because I had arranged it all erm I'd arranged for the consultant to come out, not our consultant, a consultant from the community mental health team, spoke to the family got the police there because this service user was quite aggressive erm, got everything arranged for a certain time, section 12 GP had agreed to come and then the consultant turned around and said he couldn't come. (Nurse 05)*

As a consequence, the assessment process had to start again, the result of which was a delayed start time for the participant also extending her working day quite significantly and again there is a sense of an underlying dissatisfaction:

*So, you are going to have to rearrange the whole process again later on in the evening. So I'd been in work from half seven the assessment was arranged for four o'clock, I'd got a bed located everything and, then I had to go out and sort it all out again. (Nurse 05)*

She again justifies the sabotage; this time in the eventual, and in her opinion, successful outcome of the assessment. The process, as she reports, all went smoothly including the location of a local bed, a seemingly better outcome:

*So, I was still here at nine o'clock at night but, having said that when I did the second assessment erm I got the bed more locally because somebody had gone off the ward, so I got a local bed I got the consultant and GP out within an hour of ringing them both and, as I got there GP, consultant turned up, police came at the same time. It doesn't normally happen like that. (Nurse 05)*

Her underlying frustration is however clear in her picture in which she depicts the pressure of time and of being subject to the doctor, placing herself underneath them in her drawing with beads of sweat and the wording 'aagh' to reinforce her frustration:

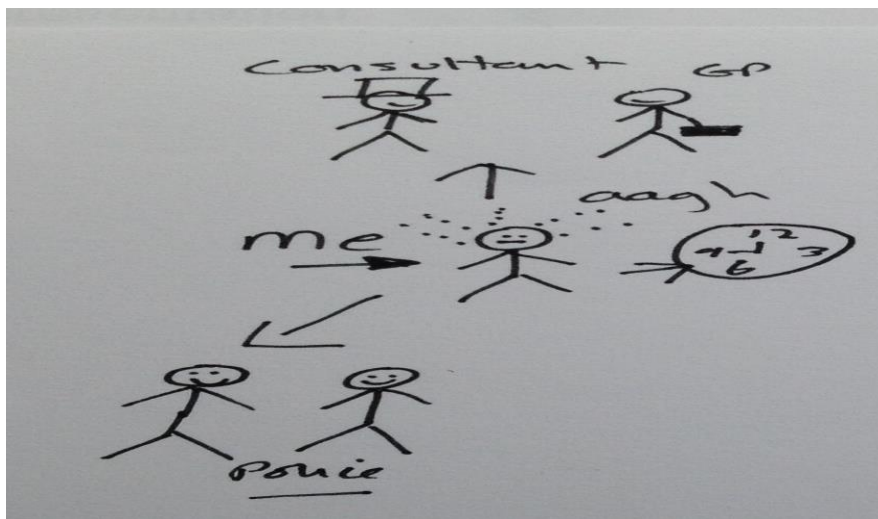


Figure 4.13 Excerpt of a Rich Picture depicting frustration.

### ***Sabotage of “role over”***

Sabotage, however, is a not one-way process. On occasion it can also be directed from the approved mental health practitioner to the doctor. Another nurse participant describes an assessment which took place in a police cell. In this assessment the participant had been in role as the approved mental health practitioner and not, as would be otherwise the case for this person, a nurse in a community mental health team. Others present at the assessment include the doctor from the same community mental

health team as the participant and a second doctor approved under the Mental Health Act to undertake such assessments, a so-called Section 12:

*I was in the [police] cells seeing somebody at the police station last Friday with my consultant from the team, although I was working as an AMHP not as [a member of the community mental health team] and a section 12 doctor. (Nurse 02)*

The person being assessed was deemed potentially violent and the doctors had ensured their own safety during the assessment by positioning themselves near exit routes and panic alarms. The assessment is conducted during which the person shows signs of aggression towards the participant:

*And this guy was quite highly aroused and the police doctor has asked for a police officer to be in with us. He'd taken care to ensure that the seats were in a certain way that we were near the exit and that we could touch alarms if we needed to. And we did the assessment and we looked at alternatives and we thought that we could probably manage him in the community. But, he was still quite highly aroused and he'd been quite aggressive to me when I had challenged some of the things that he's been saying. (Nurse 02)*

The participant and the doctors decide not to go ahead with an application to hospital and, in spite of the careful preparations which had been made by the doctors to ensure their own safety along with the aggression shown to the participant during the assessment, doctors were willing to leave her in the same, potentially violent, situation. The participant shows her disbelief at this:



*After we went back to his cell and we talked about the outcome and we were all in agreement that he could go home with support erm and the consultant said to me, 'right so I'll leave you to let him know then....ok then, see you later' and I thought, thanks for that. Do you know what I mean - you've just gone to all that, all those lengths to preserve yourself and to make sure that you're safe and now it's right, it's Friday, it's ten past five, I'm out of here. (Nurse 02)*

As if to add to the sense of being abandoned, the participant goes on to describe the doctor's attempts to also delegate the required administrative tasks:

*And then he did also say can you document everything you know on our record our electronic record system. (Nurse 02)*

But, she refuses. The participant sabotages the abandonment and feels as if she has, in a small way, clarified role boundaries:

*I said, "no sorry no that's, you need to do that I'm the AMHP here you need to do that. I've got my action form here to complete. You need to go and do that."*  
*And he had his tail between his legs a bit. (Nurse 02)*

Similarly, another nurse participant reports not initially going ahead with an assessment despite a request from a doctor. At first the doctor orders them to undertake an assessment:

*This is how she is presenting saying this and she's saying that she's really ill and I think she's psychotic. She needs to be brought into hospital and I want you to do a mental health act assessment right now. (Nurse 05)*

But the participant stalls:

*I say oh, ok well, you know, let me just see what I can do and I'll get back to you. (Nurse 05)*

### ***Sabotage of traditional roles***

The sense of a growing tendency by participants to view doctors at least as their professional equals and to not defer to their supposed superiority is evident elsewhere in the data. One social work participant recounts the shock her own mother expresses when she realises that her daughter, even when undertaking an authoritative role such as an approved mental health practitioner, would actually speak to the doctor and use their first name as if an equal:

*My mum's like shocked that I call doctor by their first name you call him Myles, you speak to him! (Social Worker 03)*

The participant, however, views this way of conducting the relationship with the doctor as normal for her and begins to try and fathom how this has come about. Although she appears confused in this questioning, she does muse whether there might be a difference between how the doctor is viewed by a member of staff in an inpatient setting as opposed to a member of staff in a community setting:

*That's you know that's just normal because that's how I see my job. Maybe inpatients teams more than. Community health staff will challenge. Mainly inpatient teams. Well that's what the doctor says, we don't agree with it but so maybe that's the thing where I think well maybe an inpatient nurse couldn't not couldn't. (Social Worker 03)*

Even so, she does not doubt that, with appropriate training any “human” can undertake a doctor’s role:

*Course they could that's like saying when someone's not a surgeon then they couldn't do surgery well then they couldn't but if they had the training then hopefully they would be able to do it. I mean they are still human so they are not programmed differently. (Social Worker 03)*

A nurse participant is much more vehement in his belief that doctors are not omniscient:

*Oh yeah, because they are not always right, they are not always right and I've had many a ding dong down at the police station with doctors. (Nurse 03)*

He, however, feels that not all approved mental health practitioner colleagues are as willing to disagree with a doctor who has signed a medical recommendation and thereby giving his opinion that the person being assessed needs to be in hospital. This participant, by contrast, “thrives” in doing so:

*I've heard an AMHP telling me that if they've got two medical recommendations, they've got no choice but to make an application. Now you work that one out. I don't know what's the point going, what's the point of the role I thrive on saying no to doctors. (Nurse 03)*

He makes clear that the power to make an application rests ultimately with him although he recognises that such assertiveness comes through confidence in the role which others might not have:

*And ....if I feel it's appropriate I'll make an application and they'll go in and get treated dud der duh der not a problem, but when I don't believe in it, it won't happen and I'm quite assertive erm clear in my own mind what is, but I think other AMHPs who are less confident I should say will be, have been erm made*

*applications simply because they have got two med recs [medical recommendations] and won't challenge it. (Nurse 03)*

He goes on to disparage what he believes are the actions of some approved mental health practitioners who sign an application for admission once they have the two medical recommendations. For him, the AMHP role is not merely bureaucratic or administrative nor indeed one that anyone could train to do. Rather, it is one that necessarily requires ability on the part of the person to critically reflect on doing so:

*The doctor's right, you've got these two bits of paper [medical recommendations], got the patient there two bits of paper right where do I sigh right you are off to ....see ya! What's the point in that? There's no point. You could train a YTS [Youth Training Scheme] kid to do that. I think it's all about how you where you come from, where you are what sits comfortably, how you critically reflect and the day you stop critically reflecting is the day you just jack in. (Nurse 03)*

He too, feels the lacks of confidence in others might rest in the traditional, deferential hierarchy found in what he feels are traditionally medically dominated psychiatric services:

*Well the nurse does what the doctor says. I'll prescribe this and the nurse gives it. Du der duh duh der. Get on with it. The doctor's always right and that goes back to Florence Nightingale or whatever. But nurses, particularly the team I work in, that's not as prominent. That's not really the culture here. You are autonomous and I'm always happy to question doctors really. I mean I don't have a problem. (Nurse 03)*

More profoundly, this participant views the fact that he is prepared to challenge doctors symbolic of the decline in traditional psychiatry:

*Doctors are still very traditionally still, very traditionally minded follow the medical models and I think if that's about them perhaps losing their professional identity really and clinging onto it by over medicalising, pathologising things. If it's pathologised you can treat. Therefore the doctor can prescribe something, give it a name stick it in a big red book somewhere, and label it. I think it's all just nonsense really. (Nurse 03)*

He goes on to provide an instance whereby a female has been diagnosed with what for him is a spurious psychiatric illness, although he does acknowledge that this is his interpretation only.

*I mean we have been to see a girl this morning she got a diagnosis of bipolar disorder. She hasn't got bipolar, she hasn't never has done. She's got a diagnosis of it but doesn't mean she's got it erm and there's a culture particularly in this area in the nineties anyone who went within five miles of ...hospital got bipolar disorder diagnosed. Everybody, if they are upset and crying weeping and wailing got pscyhothymia – good one that like rapid cycle of moods, what does that mean it's rubbish you know, so I just think they are losing their grip on things and compensating in other ways that's my interpretation. (Nurse 03)*

For him, the real focus of the approved mental health practitioner role lies not within such spurious diagnoses but rather in the assessment of risk. Moreover, he feels that this challenge to a doctor's authority is the crux of the role. He also feels that this view is even stronger than his social work colleagues:

*Although I'm a nurse I think I am more anti-psychiatry, critical of psychiatry than most of my social work colleagues, I do, I mean, I am not. I think my colleagues would perhaps agree where that comes from I don't know why I think being here for so long seeing the same people over and over again for a number of years. It's not about very rarely is it about an illness, it's about risk and I always say well it's about how you deal with that and how you can contain it and I think I am quite skilled at risk assessment really and you always get well this is high risk. Anyone going up Helvellyn in the winter time is a high risk are you going to chuck them in hospital as well. I mean I don't know I could be here all day talking about risk. (Nurse 03)*

He views inpatient psychiatric acute wards as being for the interests of medical and other clinicians in that they house "ill people" and not, necessarily, for the interests of the patient. His motivation for undertaking approved mental health practice is to influence this use:

*That's my perception of things I mean going on acute wards is not the answer. It helps the clinicians, it helps the people who don't know what to do erm but it isn't always in the person's best interests erm that was why I erm wanted to be in a position to be able to make those decisions. (Nurse 03)*

Finally, he suggests that the approved mental health practice role is an independent one and not one in which the typical, that is deferential, nurse-doctor relationship is present:

*Absolutely independent. Although I'm a nurse I don't share typical nurse doctor opinions. (Nurse 03)*

## *Summary*

Throughout this section of the data analysis, participants, irrespective of their professional background, gender or longevity report that they are left to complete the assessment sometimes alone and, on occasion, in physically dangerous situations. What, in effect is experienced as an abandonment happens once the doctor has themselves determined that their own part, the signing of the medical recommendation, is achieved. On occasion, doctors sabotage the assessment even before it begins and despite arrangements which have been made to enable them to partake. Participants who report such sabotage on the part of the doctor also find ways of justifying it. Participants in addition seem, at first, resigned to being abandoned during the process. But, further analysis shows dissatisfaction; most participants deem this abandonment as doctors relinquishing responsibility and, moreover, working with little understanding or compassion for their colleagues. Furthermore, there is evidence, either from reported actions or expressed attitude of approved mental health practitioners acting on this dissatisfaction. Some participants attempt, and on occasion succeed, in sabotage towards the doctor. One participant even compares such 'sabotage' as a rejection of the conventional, deferential relationship between a nurse and a doctor and, ultimately, of psychiatry as it is traditionally practiced.

## **Praxis**

### *Introduction*

Present in the description by all participants throughout this section of the data analysis is the belief that the person is central. Based on the understanding that an assessment is a major life event, participants are able to impart empathy and being protective despite

what the person being assessed may have carried out. Ultimately participants use this shared value to defend the role.

### ***The use of person***

The significance of a mental health act assessment for the individual subject to it is summed up in the following quote in which a participant describes the process as a “big deal” and something which is not an everyday occurrence:

*When someone is being assessed under the Mental Health Act it's like such a big deal and you should always remember that and I kind of think we do this every day but this doesn't happen to them every day even if it's ten times. I mean it's only ten times. (Social Worker 03)*

Enabling as positive an experience as possible for the individual subject to such an assessment is understood across the range of participants in this data analysis. This includes social workers:

*It's how you say it and it's not what you do it's how you do it sometimes you can be doing something not very nice to someone like hurting them because you are taking blood but if you do it well and they kind of go away with a better experience of it. (Social Worker 03)*

The enormity of a mental health act assessment and the desire to be sympathetic to the person and their family is also understood by nurses:

*If you can and it's in your power you don't do any of that [make a public scene] you do it as nice as you can because its traumatic for the family as it is because you have got to do it as nice as you can because they have to live with the consequences of how you do that. (Nurse 05)*



An occupational therapist also puts the person and the process foremost:

*Good AMHP practice is remembering the person and the other end of the assessment and why you are doing it. (Occupational Therapist 01)*

Participants emphasised that the process of assessment includes fundamentally how it is experienced by the person; process is not just a series of actions or functions. The experience is deemed important despite the reality that the need for involvement from an approved mental health practitioner may have a potentially negative outcome; to deprive someone of their liberty:

*You know you kind of you are not the nice guy always when you do the mental health act assessment when you are kind of taking somebody away but I kind of think it's your role to be yes you might decide to take someone away but if you are nice and you do it professionally and you do it well then it doesn't have to be as awful. You know it is important how you do it. (Social Worker 03)*

Other participants also see the person as central, stating this clearly in the data. One social work participant declares that the person should always be central on this occasion when describing the picture they had drawn (see Figure 4.14).

*I started in the middle and I put the person in the middle because that's where I feel they should always be (Social Worker 05):*

This same participant is also clear and depicts this in her picture that, even though she has to juggle other demands in the process, her focus is to keep the person in the centre:

*So, I've got my little bag of section papers but of course I'm juggling trying to speak to everybody so I've just put that I'm juggling but I've got to try and keep this person, erm, central. (Social Worker 05)*

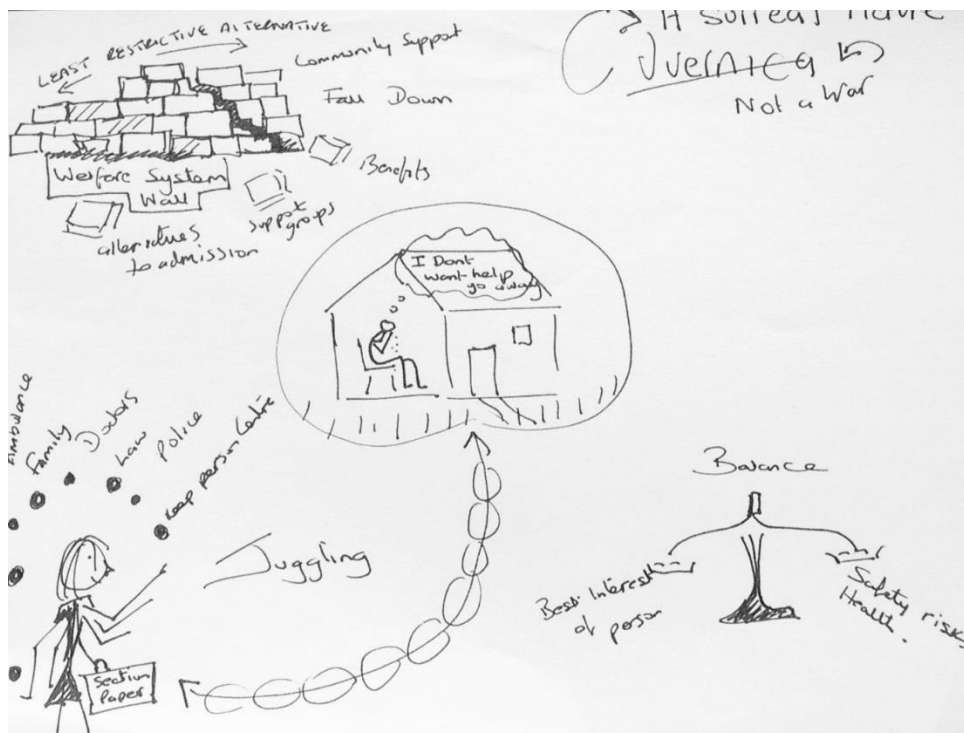


Figure 4.14 Whole Rich Picture depicting person in the middle.

At other times there is an acknowledgement that the assessment process has to be balanced but nonetheless still based on the principle of keeping the person central as she has also included in the picture:

*To me my values are in terms of being person centred and trying to do the best for the person in the situation even though you've got to balance the safety and the health of the person against and then with the best interests of the person you are trying to do the best for everybody in that situation. (Social Worker 05)*

A powerful and repeated metaphor which evokes the strength of the use of person is that of being chained and underpins the theory of personhood:

*What I want to do is have some kind of a link to that person, to me there, because and that's a big chain link if you like you know, just making sure that*

*you keep that, that you have that chain, that strong link with me, to them. (Social Worker 05)*

She also emphasised this as she added it during interview:

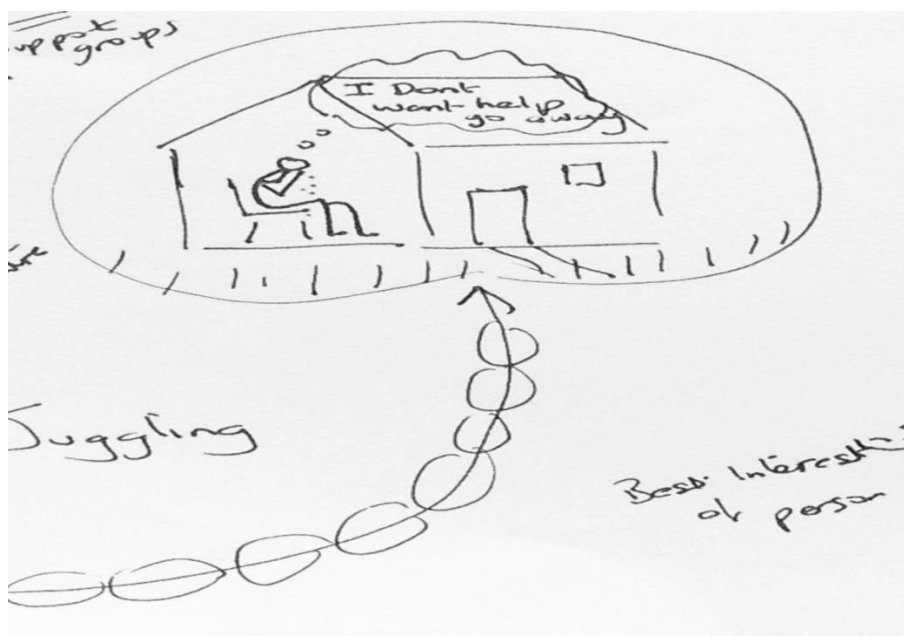


Figure 4.15 Excerpt of a Rich Picture with chain added to depict connection between participant and person.

Also, more pragmatically, other factors involved in the assessment might sometimes seem more central because they demand extra. Nonetheless, as another social work participant indicates the person remains central:

*You know all these other considerations and that individual actually...I wouldn't say I don't put them at the centre of it but it would certainly be true to say that they are not, erm, the most demanding bit of the assessment. (Social Worker 04)*

It is interesting to note the stark portrayal of this in the participant's picture:



Figure 4.16 Whole Rich Picture showing various tasks and person at periphery.

### ***The use of person: empathy and being protective***

The principle of keeping the person central develops and is further reported by a social work participant, on this occasion when she was assessing a man with past violent and aggressive behaviours. Despite the history, this participant remains able to recognise the person, putting to one side any disregard. Such empathy, she reports, is an essential part of approved mental health practice.

To begin, she outlines other professionals' opinion of the man being assessed:

*The police didn't see a person they saw a rapist or a violent racist who's raped people. They wouldn't share lots of information with me so I don't know the ins and outs and that's fine up to a point, because it's factual, and I think he has done those things. (Social Worker 03)*

She, instead, elaborates on this by recognition of his individual situation as a person, here that he is a father:

*He isn't just a rapist is he you know he's somebody's dad at the end of the day, because he was. (Social Worker 03)*

She also compares this with her own situation as a mother:

*And I'm not just an AMHP I am someone's mum (Social Worker 03)*

Recognition of the person by likening aspects of the individual being assessed to herself, this participant is clear in her belief in that those she assesses when undertaking approved mental health practice are persons, just like her. For her, to not treat them as such, regardless of previous behaviours, is a personal failure. Given that she was describing this is the context of her approved mental health practice to not do so might also be perceived as a professional failure:

*You know you might not know this stuff about someone but what you do know is they're a person so you know just like you can get blood out of me you can get blood out of them so you know there is lots of similarities I think I don't know just thinking about treating people as human beings if you if you are not nice to someone then that is a failure in yourself. (Social Worker 03)*

This belief that people being assessed are persons and their recognition as such is vital, is echoed by a nurse participant, albeit she refers collectively in this instance to her family:

*It's not just about being good practice it's about being you know you've got to treat them how you hoped one day if one your own family did it somebody would treat them the same way. (Nurse 05)*

And later:

*At the end of the day the family you know it could be your family. It's only by the grace of God that it isn't your family and you'd hope that if it was your family it would be somebody who you knew was approachable, had your best interests at heart, wasn't just going to do something for the sake of doing it or because they thought best you know It's got to be an all-round approach. (Nurse 05)*

The use of person as shown in the data continues to develop; those being assessed should not only be recognised as an individual person and treated as such but also as people in need of protection. One social work participant refuses to carry out an assessment on a woman in the woman's workplace as she feels to do so would be an infringement of her personhood. She likens the way in which it is suggested the individual should be treated as being like a suspect in a murder enquiry:

*I mean this was a lady who worked in an office building nearby and she was at work and they said well can't you just go and get her and I said not really I don't know what you think we do but I'm not walking into someone's place of work and taking them I mean the police very rarely do that so no unless it a murder enquiry but I mean I don't know even if then the police would do that. (Social Worker 03)*

In what appears to be a sudden insight, putting this principle into action is expressed by this same social work participant albeit in reference to a different person being assessed:

*If ever there was a person that was vulnerable and that needed his rights safeguarding that day it was him regardless of anything else, he was incapacitated... I'd never thought of that, but that, that's what I was doing isn't it? (Social Worker 03)*

This realisation encapsulates praxis or, the process by which a principle, in this instance keeping the person central and protected, is enacted.

Furthermore, this realisation is, according to this same participant, in direct contrast to that of other non-approved mental health practitioners whom, she contends, do not put this principle into action. The difference between her individual response and that of other non-approved mental health practitioners is repeated by her:

*The police were saying he's not a nice man he's not a nice man, history of race assault, racially abusing people in and out of prison, drug user, aggressive.*

*(Social Worker 03)*

Her thoughts remain rooted in the understanding she has of the man as a person, especially so given that he is in a vulnerable and incapacitated situation:

*And I kind of think that's as may be [he's not a nice man] but he was found with his trousers around his ankles looking to have been covered in cuts and bruises and you kind of think well he's vulnerable I think he was off his face on something as well so he couldn't make, he couldn't make his views known. So, in a way, when you are kind of thinking of not being judgemental. (Social Worker 03)*

This participant is clear that when undertaking approved mental health practice she can consciously put any judgements about the person to one side or “leave them at the door”:

*You kind of have to leave all that stuff at the door about what he may not or may have done, but the police couldn't and I think as a professional I am affected by information I receive but in terms of how we proceed legally and how we*

*proceed in his best interests we have to leave that at the door. (Social Worker 03)*

Her opinion is that she, as an individual practitioner and moreover approved mental health practitioners on mass, should not judge the person or their behaviour. This, she repeats, differentiates her practice to “a lot of other services”. For her, these “others” are not bothered that this man might die and were he to do so, it would be “no great loss”:

*He had a road traffic accident the day before we assessed him erm he'd been fitting he'd left A and E [Accident and Emergency] before he'd been fully assessed and there was a real concern that is this a brain injury that we are seeing or is it LSD or is it something else and a lot of the other services were like I pretty much don't care if he dies you know erm it would be no great loss I think that was one of the things that was said and I thought that as may be to society as a whole it may be but that's not our job that's not what we are here for. (Social Worker 03)*

In defending the person here, the participant also defends “the job”. “That’s not our job, that’s not what we are here for”. This is a further example of praxis but here where the principle being enacted in practice refers to approved mental health practice as a whole.

Such praxis is not contained to this specific participant or professional group but is also present in the interpretation of the data of other participants who, too, enact the principle of the use of person through respect, being protective of individuals and, in turn, defending approved mental health practice.



### *The use of person: defence of approved mental health practice*

A nurse participant describes the attempt by him to block the request that an assessment should take place. He believes this request to be unsound, despite medical opinion to the contrary. The nurse questions whether the assessment is needed and also believes that this is wasting time and resources. Nonetheless, the assessment process which included the participant as assessor does start despite his disbelief seen here and described as a raised eyebrow:



Figure 4.17 Excerpt of a Rich Picture depicting a raised eyebrow.

*So we went through all, this is the main question raised eyebrow, really? (Nurse 03)*

That he views this all as a waste of time and administrative resources is depicted in his drawing and description:

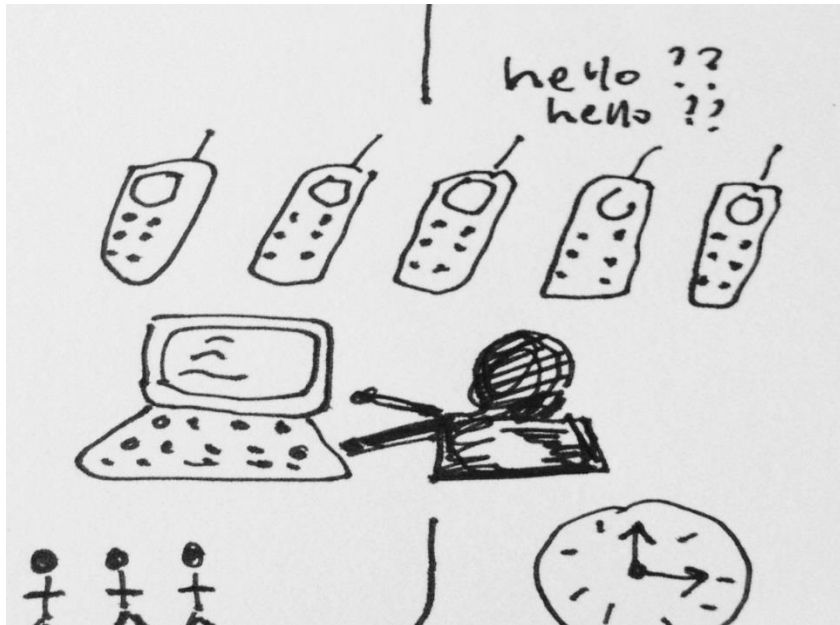


Figure 4.18 Excerpt of a Rich Picture showing waste of time.

*All the 'phone calls, typing into the computer for three hours on end. Time, this is the time that it's taking. Managed to arrange it, the assessment. And we all went out. (Nurse 03)*

He goes on to describe the scene on arrival. The person being assessed was in his view undertaking seemingly 'normal' activity, in this instance having been on a trip to the garden centre:

*As I got there she I pulled up I was early. I pulled up I was waiting for the other two gentlemen [the doctors] and she is getting got her car boot open. She had been to the garden centre. She got stuff out of the back of her car into her house going about her own business, minding her own, right as rain. (Nurse 03)*

The person who was being assessed was known to medical staff. On the arrival of the doctors the woman, having recognised them and being thereby alerted as to what might be about to happen, decides to drive off. The nurse can see nothing wrong with this wondering if he is "missing something":

*Doctor turns up who she recognises, so she goes back into the house gets her hat and coat on gets into her car and drives off and I'm looking around thinking am I missing something, am I cracking up here or what is this, am I missing a trick. (Nurse 03)*

The nurse ultimately decides, as was his initial thinking, that an assessment should not go ahead despite the doctor suggesting that the police be called because the doctor remained worried:

*So, the doctor said we need to call the police. Call the police for what? I said if we had never turned up she would be as right as rain. So, I'm worried about her. So, I said well, if you want to call the police, you call the police, but I'll tell you another thing I won't be proceeding with this [the assessment]. (Nurse 03)*

It is clear from the outset that this participant did not agree with the need for the assessment and depicted this frustration in his picture in an ironic 'gun to the head' metaphorical depiction of frustration by the participant, rather than suicide:



Figure 4.19 Excerpt of a Rich Picture depicting a gun to the head.

His description also underpins this frustration which for him is based on two issues; the inappropriate imposition of another's values, in this instance medical ones as to what

constitutes normal behaviour and also his belief in the futility of medical intervention in this particular instance:

*The frustration, kind of how much work that generated for something which for me was inappropriate and unavoidable and frustration anger erm and just a complete and utter disillusionment about the whole process about doctors imposing their values on people who think they have been treated. She is not treatable, they aren't going to treat her. One, she won't engage in treatment and two it's about imposing their values on this lady who poses no real risk. She's angry, she may have a case. (Nurse 03)*

This participant is clearly defending the person and their right to 'normal' life but is also expressing frustration about other professionals. For him, the work is of defence, of the person but also of approved mental health practice and its significance.

For other participants, defence applies even on occasion towards other colleagues. Here a social worker shows affront at another approved mental health practitioner who, she feels, was ignoring the person:

*We were on a ward and the guy was rambling and hallucinating and we were you know and you do feel a bit silly sometimes when you are just talking to someone like this and ..... and er this ASW [AMHP] went, we are not getting anything out of him he's getting sectioned and I thought you did that in front of him you did that in front of him that's not ok you know that's the same as slapping him really how dare you do that in front of him and I couldn't well I felt at the time that I couldn't challenge her in front of him I mean she's a lovely woman and she was really experienced and she was also right [in her decision-*

*making] but that's not the way to kind of go about that and I think he may remember that later. He might not. (Social Worker 03)*

In this situation, when the person being assessed seemingly does not have the capacity to remember what might be happening, this participant still feels that how the assessment is experienced by the person should always matter. The use of person, is for this participant fundamental to approved mental health practice, not just to the process.

### *Summary*

The use of person, is fundamental to approved mental health practice, not just to the process. Person refers to both the person who is the practitioner and the person who is experiencing assessment. This use of person is a principle which manifests itself in feelings towards the person being assessed and includes respect, empathy and being protective. As these data illustrate, we may term this emphasis praxis because participants foreground the 'person' in defence of their individual practice specifically and also of approved mental health practice generally when it is deemed that such use is not being enacted. They defend this principle both to non-approved mental health practitioners and also fellow approved mental health practitioners. It is identified as significant because personhood, is being embodied in the how not just the who of practice. This realisation is also used to defend the individual and in defence of undertaking approved mental health practice. Such process is praxis, a substantial finding in this analysis and pertains regardless of professional background.

## **“Pull”**

### *Introduction*

In this section of the data analysis, participants discuss the simultaneous presence of contrasting and seemingly incompatible emotions when undertaking approved mental health practice. To begin, participants report potentially detrimental emotions such as anxiety and fear, along with a sense of there being a negative impact on their own abilities when having to deal with conflict and risk. The presence of these emotions also leads them, on occasion, to question their own approved mental health practice. However, at the same time, participants report emotions such as satisfaction and also pride in having done, what they believe, is a good job. In so doing, participants concurrently demonstrate self-assurance in their role.

### *Detrimental emotions*

One nurse participant speaks of her enjoyment of undertaking approved mental health practice and the sense of security she feels when undertaking it which she feels is a result of the existence of the legal framework:

*People ask me erm whether I enjoy my AMHP role erm and I do, I really enjoy it and I always say it's because you are working within a legal framework which I think gives you a sense of security. (Nurse 02)*

This framework is depicted by one participant in their picture as rule book that is closed, not open, but a source of exclamation too (Social Worker 03):

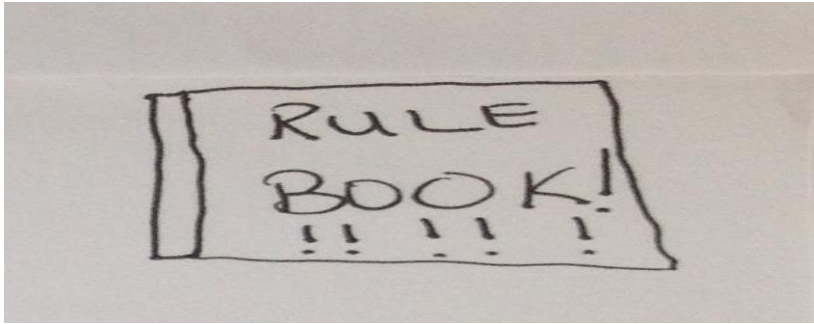


Figure 4.20 Excerpt of a Rich Picture depicting a rule book.

However, this sense of security is also accompanied by other, potentially detrimental, emotions. First, the feeling of anxiety is common. One nurse participant describes his anxiety rising at the point in the assessment where the decision to admit to hospital under a formal section has been taken, but is delayed as they await transport to hospital. His anxiety concerns the safety of all involved, including himself, and also that the situation is becoming unmanageable:

*So we've come down now to safety there's me, the ambulance, care coordinator, family so they are what's happening my anxiety is up because I'm thinking this is all going pear shaped. (Nurse 01)*

Meanwhile, an occupational therapist describes the emotional impact on herself of having left a person at home with family in the absence of a hospital bed:

*I was quite anxious really, very anxious. I couldn't sleep when I got home. I was thinking oh no, that lady was still left. (Occupational therapist 02)*

A social worker describes the moment when the police car which had been called to assist has driven away. He wishes that the car and its occupants would return:

*It can still be anxiety provoking. I mean I've just looked back at my drawing and erm I've got like a, I'm at somebody's house and I've got a police car driving away and I'm like 'come back'. (Social Worker 02)*

He illustrated this in a part of his drawing:

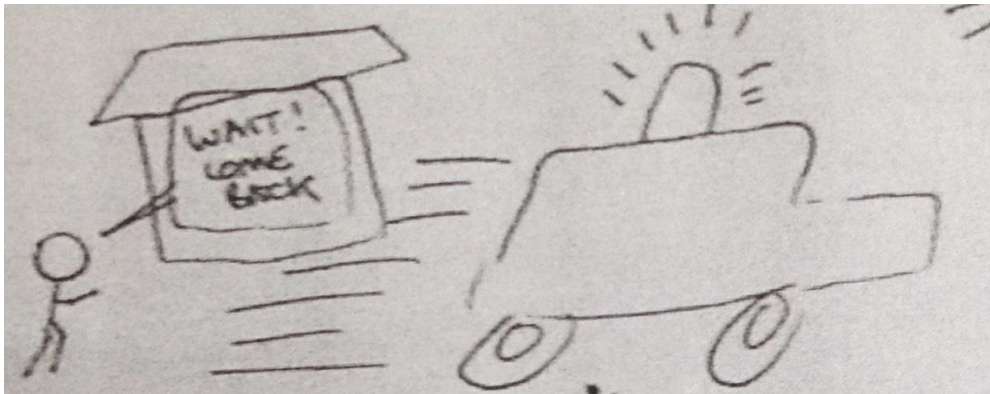


Figure 4.21 Excerpt of a Rich Picture showing police car driving away.

A second social worker describes a series of assessments for which she had been responsible, describing her own physiological responses as well as the long and sometimes unsocial hours worked:

*I practically had a panic attack before I went out as I was going out from one to the next finishing late and then out early the next morning trying to make sure, starting at seven thirty, that I tried to have everything in place. (Social Worker 05)*

In addition, other emotions, especially when dealing with conflict and risk, are also displayed. A social work participant uses powerful terminology to describe conflict with other professionals. She describes the feeling of being subject to the wishes of others even to the extent that this was impacting negatively on her perceived ability to “do her job”:



*I really felt on Wednesday that I was somebody else's bitch. That is not a great way to describe it but I just felt like there were all these people yanking my chain and I was there to do a job but I was being stopped from doing that because all of these other people wanted a piece of me and wanted their views known and their needs met and their targets. (Social Worker 03)*

She also captured this in her drawing which depicts herself as enchained by the demands and expectations of others:

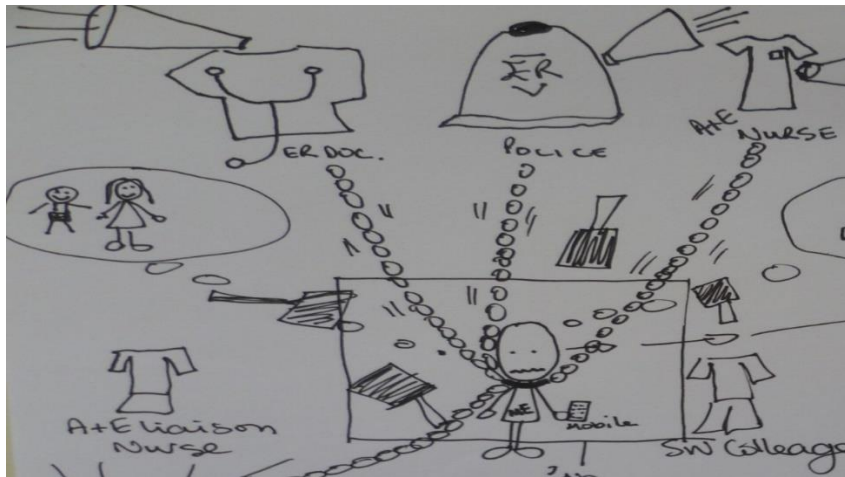


Figure 4.22 Excerpt of a Rich Picture illustrating participant being chained.

Another social worker speaks of the possible risks which might occur due to the circumstances of the person she was about to assess. She reports her unhappiness in not forewarning this person about the assessment and questions whether she has undertaken her practice properly, either in what action was now being suggested or in what had happened up until that point:

*My concern about this man in the house is that nobody wanted to tell him we were coming and I was unhappy about that because of the situation with chasing his brother, with him having a knife with his wiring his electric up, the door handles up to the electric. They was saying no, and I had to agree well no,*

*you're right. And he was out all day in his car so we had to go first thing in the morning. So you know you make those decisions about how you are going to plan things and whether it's right, erm. You trying to look at least restrictive options. Is there anything else that should have been done before you get to that point? (Social Worker 05)*

### ***Positive, and contrasting, emotions***

However, analysis also reveals that, alongside these potentially detrimental emotions, participants also experience positive and seemingly contrasting emotions such as satisfaction and pride. For instance, a nurse, whilst acknowledging that making an application and detaining someone is never a good thing, also describes a sense of satisfaction of having done a good job:

*You can never say there is anything great about detaining anybody on a section three [of the Mental Health Act 1983] I did feel a certain sense of satisfaction I said that afterwards. (Nurse 02)*

She also reports a sense of pride in being complimented on having done this good job by an experienced colleague:

*And it was nice that my social work colleague did actually compliment my practice. She's an experienced social worker and I felt quite pleased about that in some way you know. (Nurse 02)*

Another nurse described a "lovely assessment" illustrated in her picture by a symbol of a heart (Nurse 3):

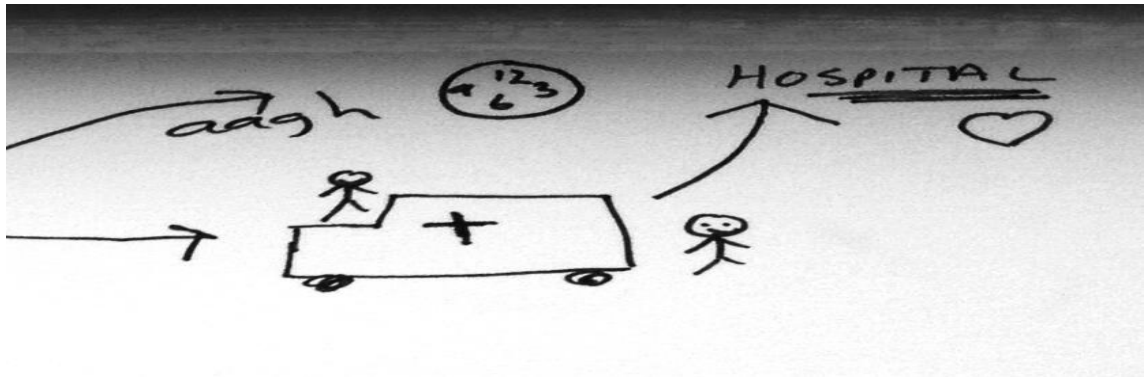


Figure 4.23 Excerpt of a Rich Picture depicting a lovely assessment.

While the picture also contains illustrations of her frustration, here in having to wait for an ambulance, she described the heart in her picture as meaning a best outcome for person and their family. She felt she had done a good job and that a hospital admission was needed in order to provide the appropriate treatment.

The sense of doing a good job and enjoying the role, despite having much to do, is also repeated, again by a nurse participant:

*The senior practitioner who was backup that day she said she really enjoyed it you know the environment she was in she said it was you know it was very busy and it was hectic and there was a lot of stuff going on and we were throwing a lot of things around it was a really nice atmosphere to work in. (Nurse 02)*

It is when participants reflect upon their approved mental health practice that they begin to infer dissonance. One social work participant suggests that the paperwork which approved mental health practitioners are required to complete after every assessment should not just be used administratively but as tools to enable them to think about their approved mental health practice:

*You know, when I was looking at the, erm, the paperwork for the way in which we record our assessments. You know I want it to be helpful, I want it to be something that encourages you to kind of get to certain points and reflect. (Social Worker 02)*

A similar need for reflection is also expressed by a nurse participant when she ponders being satisfied. For her, this satisfaction is not about being happy about the outcomes of her approved mental health practice but about having done a good job:

*I feel like that a lot of it's about reflecting isn't it? You know, about how situations have, how you've found situations and yeah I felt I wouldn't say I felt happy because I don't think you can feel happy but I felt satisfied at the end. (Nurse 02)*

In particular, emotions, especially those which might otherwise be detrimental, are actually viewed as “healthy”. One social work participant describes a benefit in being anxious in that it is compelling him to be thorough:

*You know, in a way, you know, I think this anxiety is a healthy thing (because you know I don't want those [negative] consequences) that motivates me to want to be thorough. (Social Worker 02)*

Meanwhile, an occupational therapist believes that being nervous is good because it stops her being too casual about what is a very important decision, although she warns of not allowing herself to be too nervous as this might render her unable to undertake her role:

*Because the day that you are not nervous then you could be making a mistake you could be too casual so it's ok to be nervous In fact it's good. Not so nervous that you can't do things properly, but it's to have that bit of anxiety because it's something that has big implications. (Occupational Therapist 01)*

A nurse participant describes pressure as a good thing because its impact is that it motivates thought:

*Yeah and like I say you know sometimes pressure's good it gets you thinking.*

*(Nurse 01)*

While another nurse speaks explicitly of needing the feeling of anxiety to counteract complacency:

*I mean there is anxiety around assessments there always will be but you need*

*that 'cause the minute you've not got that then you get complacent. (Nurse 05)*

These data indicate that a range of seemingly paradoxical emotions, those which on the one hand could be damaging to confidence and those which on the other suggest poise, are present, but also that participants experience them as *co-existing* in their reflections on practice. In addition, participants also, on occasion, experience not being in control while, *crucially*, simultaneously using a contradictory emotion to achieve this. In this analysis, this active use of dissonance is referred to as 'pull'.

One social work participant is explicitly aware of 'pull'. He describes simultaneously being pulled emotionally in every direction but also, and *significantly*, not being pulled. This "letting" of "being pulled" is for this participant an acknowledgment that approved mental health practice involves the active use of dissonance:

*I think it was the bit about yeah actually being pulled in every direction is hard*

*but, actually, sometimes not being pulled in any direction you can't, you can't*

*escape. You kind of, you have to let yourself be pulled in a way. (Social Worker*

*02)*

This pull is illustrated in the picture drawn by this same participant which shows him being pulled between two opposing people whilst hovering over a hole:



Figure 4.24 Excerpt of a Rich Picture showing “pull”.

Other social work participants too understood “pull”, using the feeling of anxiety to recognise some loss of control, but also to motivate themselves to check their work whilst at the same time recognising that they may also need to control the situation. In the following instance the uncertainty refers to any violence which the person being assessed might generate:

*I think it's healthy to have that anxiety but it makes you, well it makes sure that you are checking, double checking that things are in place and you are covering for all eventualities. And the minute you get, yeah I know him, I know he could possibly be aggressive, he could possibly be violent but he knows me, I know him, you know I'm sure I can manage this situation. (Nurse 01)*

A social worker also describes the loss of control, here of not knowing what is to happen and having to think spontaneously, but uses the anxiety and sense of isolation this engenders in a positive way to carry out the work, even to the extent of experiencing it as exhilarating:

*I think it's the not knowing what's coming and so there is some sense of anxiety and sometimes isolation. I mean there is also some sense of exhilaration I think of feeling er, er stimulating, because you have got to think on your feet I suppose.*

*(Social Worker 01)*

And another social worker describes the process of being aware that she has to assume control, here to keep all parties calm, and yet simultaneously recognising that control is not always constant and that this is an expected part of the way in which she experiences AMHP work:

*I could have drawn another picture. It would have been me being assertive taking control of that even though I felt, you know there's a lot of people here; there's the doctor, the assessment, a lot of people, there's him, the joiner all these things erm I think what I would have liked to have drawn is a bit of a rough sea really, because at the beginning you are getting all the information in and you are coordinating and everything and then it's pretty rough and rocky. But, actually, because it's organised and you're there coordinating that service. What I may have drawn was a sea that was beginning to be a little bit calmer because you are there you are keeping the situation calm, you are staying in control, you can't always stay in control of the situation. (Social Worker 05)*

Similar explicit understanding of “pull” is described by one social worker using the simile “keeping a lid on things” or, in other words, being aware that being in control is needed when she works as an AMHP but that past experience, for her, suggests that control is not always a constant thing:

*I've really got to keep a lid on this situation now because this could get out of my out of my control, because it can do but it didn't and it went, it went really as*

*well as could be expected really so it went ok and there was no incidents. (Social worker 05)*

The same understanding applies equally to nurse participants. One nurse spoke of being in control of the emotion in the situation despite how this might appear outwardly:

*You know respectfully you are an ambassador for services you try and put some you know this is ok, things are happening it's under control. It's not as chaotic as it looks. (Nurse 01)*

The use of contrasting emotions in their practice is shown when participants in effect use feeling to 'hover' over the situation and to slow it down. This is illustrated by one nurse who talks of being in two places; "down", or "in the situation", and "up", or "overlooking it". In this instance the participant pulls himself into the situation:

*So you've got a million things going through so I've kind of pulled myself down here to this bit but I am also up here so I'm in two places so you know I am trying to kind of think well I've got the ops [operational] policy, code of conduct, its chaos I'm trying to keep calm I'm trying to provide a rationale for everything that is going on. I'm looking at another plan, plan B. (Nurse 01)*

One social worker speaks of slowing the process down so as to scrutinise what is happening:

*They've got to come in to hospital and I am slowing the process down a bit. I'm slowing the erm; erm making the.... I'm looking with a bit of a microscope I suppose. (Social Worker 01)*

Another social worker emphasises the surrealism evoked; that she feels calm despite the "war" that is occurring around her:



*It was very calm you know so you can still do it despite all this so it's a Guernica, it's not a war. Guernica, it's a surreal picture. (Social Worker 05)*

The meaning of 'hovering' for approved mental health practitioners is that they explicitly use contradictory emotions as a way of being in control even though on occasion this may mean allowing, albeit temporary, loss of control. This, then, is the use of "pull"; the recognition of seemingly not being in control of the process while, *crucially*, simultaneously using contradictory emotions to generate this in order to undertake required professional actions and is a fundamental aspect of approved mental health practice for the participants in this study.

### *Summary*

This analysis establishes that whilst simultaneous occurrence of emotions may appear at variance, they are experienced by participants as *co-existing* in their reflections on practice; dissonance which is actively used as a spur to accomplish their approved mental health practice. Referred to in this analysis as 'pull', and reported by social workers, nurses and occupational therapists alike, the concurrent existence of incongruent emotions and use by participants as a catalyst to their approved mental health practice is a significant finding in this analysis.

### **From "unclean" to "honorary social workers"**

#### *Introduction*

This section of the data analysis concerns nurse participants' views of the influence of their own professional background on approved mental health practice. There are three main issues discussed below. The first is convergence between the social and medical models of care which they recognise within nursing, occupational therapy and social

work. This convergence is such that they report overlooking the fact that team colleagues may be from different professional backgrounds or, where they do remember and are able to identify differences, they view these as inconsequential. The second is overcoming difference; nurse participants recognise that in undertaking approved mental health practice there is divergence from key aspects of orientation in their original professional training.

***Convergence: “there’s no difference”***

One nurse participant is quite clear that workers in mental health converge, sharing similar principles and values even to the extent that he states that he does not mind what profession or role he is trained in:

*I mean in our team we have a multi-team approach and we all share the same values and principles really. There’s no, I mean to be honest I am a nurse by training but I’m not particularly bothered what I am. I’m not. I’m not particularly proud of my profession, role, proud of what I am. I think we are just one generic worker in a mental health team. The fact that I’ve got a nursing degree doesn’t make me feel that particularly bothered about being a nurse.*  
(Nurse 03)

He repeats this assertion:

*I’m not really bothered what my role is I’ve got a nursing ticket but I wouldn’t say I was particularly proud to be anything I just come to work and get on with it.* (Nurse 03)

And feels certain that the only difference between himself and, in this instance, social work colleagues, is that he is able to administer medication:

*My argument is why be so fiercely loyal to your role and your profession. Why, what is it. Because essentially we are all in it we are all doing the same thing it just I can go to the med...there's a couple of social workers in our team and the only difference between mine and their job is that I can go to the medicine cabinet and get some tablets out, it's no different other than that. (Nurse 03)*

This seemingly inconsequential difference is repeated as such by a second nurse participant who is almost surprised to recall that a colleague of hers is actually not the same professional background as her and again views the only real difference in the way each role is executed is a nurse's ability to administer medication:

*I often forget [name] is a social worker because she's the only social worker here but her role isn't really much different from any of our roles. I mean the only way I see difference between that is medication. (Nurse 05)*

However, even this difference of execution is not perceived of any consequence since, as the participant goes on to explain, this social work colleague has been able to learn about medication:

*We, we obviously we know a lot more about medication, but [name] does know a lot about medication you know because she's worked with it for long enough, so she's got a very good understanding of medication. (Nurse 05)*

Rather than this nurse viewing the social worker assimilating such knowledge as aligning with the medical model only she views its execution as being more aligned to both it and the social model:

*Also we come more along the social model as well, as well as the medical model. I don't see too much difference between our roles any more. (Nurse 05)*

Occupational therapists, in the community health team are also afforded equal consideration:

*I don't actually see much difference between our roles. (Nurse 05)*

And she repeats this when reflecting on her past understanding of occupational therapist practice whilst at the same time placing them “on the ground floor”:

*I mean years ago I used to think that OTs [occupational therapists] were sitting there teaching basket weaving or talking about, 'let's paint pots, let's doing cooking'. In this team they are brilliant they deal with a lot of things that I wouldn't necessarily think was an OT [occupational therapist] role, but they are very good at it they get really involved on the ground floor with the carers. (Nurse 05)*

Indeed, for this participant all workers in the team are on the ground floor, including doctors and support workers, who seemingly have the same influence over what happens. The participant suggests that a hierarchical structure, a more traditional medical one, no longer exists and is now much flatter:

*OTs [occupational therapists] are very much involved in the care of them, especially in our team really we don't have that you know like support workers are down there and their opinions are not valued consultants are up there and they are God and therefore their opinion outweighs everyone else. It doesn't work like that. (Nurse 05)*

Use of medication against somebody's will is also, for her, not acceptable. Her perception is that being able to work in mental health is about understanding people in

their social context. Indeed, she reports a sense of pride in the team doctors or consultants as they, according to her, never force medication:

*I think we are all, especially with mental health, a big part of it is your social environment your social situation, the people themselves that's the huge part of it, that's mental health and that's what you're looking at and medication is just to me it's the add on. If they need medication. By the time they come to us a lot of them are poorly. We never, ever and, ultimate respect for our consultants, never ever force medication. (Nurse 05)*

Again, apart from dealing with medication, she sees no difference in the way in which, in mental health nursing, occupational therapy or social work is executed. She even goes on to exuberantly welcome such changes as she calls for it to be brought on:

*Much like social workers you know. There again looking at the social aspects with the family stuff like that but they don't deal with medication but as regard the knowledge on clients that are mentally ill how to manage them, the plan of care and stuff bring it on. (Nurse 05)*

### ***Overcoming divergence: from “unclean” to “honorary social worker”***

However, when making sense of undertaking approved mental health practice these nurse participants, in contrast, describe a sense of overcoming divergence as central to their experience. In order to undertake approved mental health practice they feel that they have to be accepted as “honorary” social workers and assume aspects of a professional role not usually expected of nurses.

The sense of entering into favoured company is described by a different nurse participant. Here, approved mental health practice is not nursing in its traditional sense,

rather it is undertaking social work and being afforded such parity, or being allowed entrance into a special group alliance:

*It's not nursely nursing, we are honorary social workers. (Nurse 02)*

One nurse participant describes that he is attracted to approved mental health practice because it aligns closely with the social model of care, adding that because of this he actually enjoys doing it:

*I mean, I enjoy it. It's something I'd looked at doing erm 'cause the reason I worked in assertive outreach teams. It was a very social model of care any way erm. We attended Mental Health Act Assessments to support for the service user, family and obviously for the staff that were attending as well. (Nurse 03)*

He also goes on to suggest that, even though he is a qualified nurse, he is attracted to approved mental health practice because he is not a typical nurse. In other words, that he has to adopt attributes different to a typical nurse:

*I really enjoyed it really enjoyed it because it's although I'm a nurse – don't know if we are coming to this later- but although I'm a nurse, I'm not your typical nurse. (Nurse 03)*

A different nurse participant as first perceives approved mental health practice as “just an assessment” and thereby an equivalent or extension of their usual role:

*Assessments are assessments. I think they are our bread and butter we've done them for years and the assessment is what it is. The assessment isn't a hard part of my life. An assessment, or an AMHP assessment, to me isn't a huge problem because it's what I do day in and day out and I'm comfortable with doing assessments. (Nurse 05)*

For this nurse participant when undertaking her approved mental health practice training she reports her surprise at having been advised that in order to undertake approved mental health practice she would have to ‘change hats’. The implication being that to undertake approved mental health practice as a nurse there would be a difference in the way in which she carried out a role, in particular the way in which assessments are conducted:

*when I first was doing my AMHP training I used to go out with these AMHPs one of them in particular we used to do these assessments and she'd be saying to me 'right put your AMHP hat on now when you do this assessment' and I'd go in and I'd be sitting there thinking me AMHP hat, me AMHP hat. Does that mean I have to do my assessment any differently? (Nurse 05)*

However, this participant was perturbed by this advice:

*And I'd be coming out and I'd be thinking I can't get my head around this because I'd just be doing normal assessments and I was just waiting for this great big revelation to hit I'm thinking you know, it must be something different whatever that AMHPs do different from what, me. (Nurse 05)*

She is relieved to be reassured, this time by a social work colleague, that approved mental health practice is no different to her usual understanding about how to conduct an assessment:

*And then one day I was talking to another social worker and he said it's just an assessment and I said well I'm waiting for the big thing to come that I am missing and he said, "no, it's just an assessment". (Nurse 05)*

She does not sense at this point any mystery in doing a mental health act assessment.

All that is needed, she feels, is more in-depth knowledge and understanding:

*Like I said before putting your AMHP hat on and putting it on when you go to do an assessment there's like this big mystery surrounding this assessment but it's not a mystery, it's not a mystery you need more in depth knowledge you need more in-depth understanding. (Nurse 05)*

The hat analogy is used again by the same participant but this time she contradicts her earlier claim. Here she very much feels that, when she is undertaking approved mental health practice, she has to put on a different hat:

*Yeah, the AMHP hat on – yes to me it isn't a different hat. (Nurse 05)*

This participant then is changed by approved mental health practice. She is not the same nurse fulfilling a different role but she is assuming a different professional identity when undertaking approved mental health practice. For her the difference is based on value driven considerations. She feels even though she was aware of matters such as human rights previously in her nursing role, these considerations were not to the forefront. This, for her, is a divergence in her former professional identity as a nurse that has to be overcome in order to undertake approved mental health practice:

*I say you had a better awareness of, because nurses really you know about the Human Rights Act and it's always there in the background, but you don't really work with it on a day to day basis as in it's not there. It's in the background and you are aware of it social workers are aware of it and work with it more, but we don't when I did my AMHP training. That, it's at the front instead of at the back after that. (Nurse 05)*



A different nurse participant describes the difficulty she first experienced what for her was the need, psychologically and cognitively to separate out nursing and approved mental health practice:

*At first I did have difficulty separating in my own head the two roles I did think going with my AMHP head on today. (Nurse 04)*

She also describes social workers in a similar position:

*And I know of social workers who think the same thing I am going in with my AMHP head on not social worker. (Nurse 04)*

However, she is convinced that the difference between the social work and approved mental health practice is much less than between that of the nursing and approved mental health practice. In particular, the difference is again the need to forefront principle driven considerations:

*But the difference is more advanced between the nurse role and the AMHP role because social work role and the AMHP role, because the principles between the AMHP role and the social work role are quite similar whereas it's quite poles apart really from nursing assessment. (Nurse 04)*

One nurse participant recounts her first experience of attending the approved mental health practice training course. Here she reports on the apparent coincidence which had occurred when she and other, unknown, nurse colleagues had unwittingly sat next to each other:

*When I did my AMHP training there was me and three other nurses and I trained at [place name] where there was only a small group 12 of us; 8 social*

*workers and the rest nurses and, interestingly, on the very first day when we walked in nobody knew anybody and all the nurses sat together. (Nurse 02)*

She at first makes light of this, musing as to whether nurses can sense each other, or “give off vibes” and similarly whether social workers are certain types:

*Whether it was because we were all giving off the same sort of vibes or whether social workers are a certain type of people but we don't know but yeah they did say it was quite funny. (Nurse 02)*

However, she also recalls the initial attitude of the trainers and her belief that she and nursing colleagues were almost treated as outsiders, or “unclean”:

*Tutors would come into the room and say ‘I believe we have some nurses present’ and it was almost as if we were unclean, unclean and we had to identify ourselves. (Nurse 02)*

Nonetheless, it would seem that this initial reception changed once the nurses had ‘proved’ themselves and were thereafter referred to as “honorary social workers” as if they had been accepted into a special grouping:

*Although certain nurses have proved themselves and they call us honorary social workers. (Nurse 02)*

This sense of being initially considered as an outsider is also recalled when she reports some social workers as being “quite confrontational” and “unhappy” when first aware that some nurses were to be trained to undertake approved mental health practice:

*I know a lot of social workers do actually say to me, and quite openly say to me, that they weren't happy when they first found out [that nurses were eligible to train as AMHPs] (Nurse 02)*

***Change to medical processes: nurses as approved mental health practitioners***

That nurse may not be 'properly' able to undertake approved mental health practice is also illustrated when participants discuss the specific relationship with doctors. The opinion that, as a nurse, she would automatically defer to a medical lead and therefore not be able to undertake approved mental health practice in its true sense is reported by another nurse participant when she recalls her initial failure to be supported to train:

*I, initially, was unsuccessful in my interview to do the AMHP training first time around. Erm, I applied and it was a different lead AMHP and she was less accommodating of nurse AMHPs nurses doing their AMHP training and she did actually say to me, she didn't ask me, she did say to me in the interview 'you know as a nurse you would find it extremely difficult to disagree with a consultant' which I thought was a bit presumptuous really. (Nurse 02)*

The participant goes on to point out what for her is the irony of this misguided opinion. As an approved mental health practitioner she challenges previous practice or, the praxis of approved mental health practice influences her professional identity. She feels that now when undertaking approved mental health practice, she actually challenges doctors more than some of social work colleagues, albeit she puts this ability to confront down to individual personalities rather than a particular professional background:

*And ironically I feel I do challenge doctors now a lot more than certain social workers but I don't think that's anything to do with them being social workers I think that's to do with people's personalities. (Nurse 02)*

Also, other professionals, here ward nurses, when an assessment is being conducted in that environment, almost expect, according to this participant, that she as a nurse will go along with what the doctor says and, moreover, that this would be automatic:

*Assessments on inpatient units I think there's kind of because there's an expectation I am from a nursing background that there is going to be automatic, that I will go along with. (Nurse 02)*

Another nurse participant repeats her sense that nurses based in inpatient settings believe that she will undertake approved mental health practice in a different way to social workers because she is a nurse. In essence, that she will have a perspective that aligns with the medical model rather than the social model:

*From all I think perhaps more with the nursing staff from the environment where I have previously worked although there has been a number of years so I have not really worked with any of the staff on the inpatient units, but I think it is the background where they are from that there is more expectation that you will do view it quite different from a nursing background than a social worker. (Nurse 04)*

The same participant reflects on the nursing role and believes that it still remains influenced by the medical model. For her undertaking approved mental health practice requires the need to overcome this influence apparent:

*I think it's very much more medicalised, the nursing role. As much as we say we are going to move away from that, and there has been, but doing this makes me realise we are not as moved away as you think and there is still quite a focus on medication particularly in terms on treatment and admission to hospital. (Nurse 04)*

Her evidence that nurses when undertaking approved mental health practice have to challenge medical processes are also discussed: first, the ways in which assessment interviews are conducted. In her experience as a nurse it had been a doctor who has led but, when undertaking approved mental health practice this role is reversed:

*In terms of the interview itself, because previously from a nurse background it's kind of been the doctor that's led the assessment, because obviously the mental health act assessment it's the AMHP that introduces the situation and speaks first and explains the proceedings. (Nurse 04)*

Second, her professional identity when undertaking approved mental health practice is based on the different perspective between herself and the doctor:

*So again that was quite a shift from what I was previously used to. And then the questions are obviously different which, to be fair, I did expect because the information that's required to do, with the perspective you are doing the assessment from. (Nurse 04)*

In undertaking approved mental health practice this participant also believes she has moved away from the influence of traditional nursing and is willing instead to consider other value driven options, a change of emphasis for her. Again, the praxis of approved mental health practice influences her professional identity:

*I am now much more aware in doing assessment as alternatives to that and least restrictive and trying least restrictive option first. (Nurse 04)*

In addition, she views this as an opportunity to take positive risks perceiving the inpatient environment, her previous default position as the less risky and easy option:

*As much as the risks maybe greater and there is a need for risk assessment and there is a need for positive risk assessments and there's a need for trying positive before that decision's made. Where I think previously, well it's the easy option to make sure somebody is removed and placed somewhere. Leave things safe so they don't have to manage that risk in an uncontrolled environment such as the community. (Nurse 04)*

She also believes that, unlike nurses, social workers approach assessments initially from a different standpoint, one which puts the community option first:

*A social work colleague, on the AMHP training, and I think that was the difference in their assessments it was always done from a community first, remain at home. An admission really, the last option so I think as I went more through the training this [difference] was more. (Nurse 04)*

### ***Changes to approved mental health practice: nurses as approved mental health practitioners***

This same nurse participant is very clear that there is a difference between nursing and approved mental health practice and, that the latter is aligned to social work:

*Things happen when you work with a nurse professional and when you've got them coming in a particular role, previously was a social work role, they still*

*kind of think to a certain extent it is very much the AMHP role that they have to do not the nursing role, I think. (Nurse 04)*

But this is not to suggest that nurse always believe that when social workers undertake approved mental health practice they do so correctly. She recalls a first observed mental health act assessment as a trainee and in particular her sense of shock at the different working practices she experienced, on this occasion relating to safety:

*First thing was when we did an assessment on an inpatient ward whereas previously from a nurse background the first thing you think about is where you are positioned in the room and you always make sure that you are the person nearest the door but then when we went in the practice assessor I was with just walked into the room and walked down to the bottom of the room and sat down which took me aback a bit because as I say we make sure that our chairs were positioned nearest the door so I found that different. (Nurse 04)*

She attempts to explain this sense of shock by viewing the positioning as perhaps more relaxed for the person being assessed but nonetheless, given that this was in a psychiatric intensive care unit she remained surprised. For her safety should dictate such practices. She therefore begins to question this particular instance of ‘social work approved mental health practice’:

*I mean I could see it from both views. It was more relaxing for the person in that somebody goes in and it's more comfortable and walks down and sits rather than looking where they are positioning themselves but then it was on a PICU so there's I was also thinking obviously there are reasons why this person is on a PICU there's that side. (Nurse 04)*

## *Summary*

Approved mental health practice involves value driven considerations such as human rights and least restriction; attributes which these data illustrates had not hitherto placed at the forefront of their understanding of what is expected in nursing. Nurse participants report experiencing a significant change from how nurses usually relate to doctors that is engendered by approved mental health practice. They also challenge the notion of ‘social work approved mental health practice’ and thereby are starting to introduce new ways of working, regardless of professional background.

## **Popping someone’s bubble**

### *Introduction*

This last section of the data uses an idiom from one participant to demonstrate the process in approved mental health practice whereby the notion of safety is disabused. This is present for the person being assessed and for any significant others. Dealing with the reaction and the multi-dimensional aspect of it are seen as a key aspect of approved mental health practice.

### ***The illusion of safety***

*I called it [the picture] pop because that’s what I think, I think at some point you pop someone’s bubble. (Nurse 01)*

To begin, the participant who uses the idiom of popping someone’s bubble makes clear his understanding of the enormity of undertaking approved mental health practice:

*I mean we are you know whether we like it or not, intruding on people’s lives erm you know it’s quite serious piece of you know legislation you use it and you*



*can take someone's liberty from them and remove them I mean the only time you can do that ordinarily is through a court of law erm so it is a massive thing to do to someone and I think that you've got to consider that each time you do it.*

*(Nurse 01)*

Detaining, or removing someone to a place where they do not want to be is for this participant the same as popping a bubble. Here the bubble means a perception on the part of the person being assessed that they are somehow safe from this process. During the assessment, this perception is disabused in this perception, on the one hand because it goes ahead:

*But, like I say, so you have come along and you've popped that and you've either for me popped the bubble of the service user because you are removing them to somewhere they don't want to go. (Nurse 01)*

For the carer on the other hand they are seeking safety in attempting, albeit temporarily, to relinquish their responsibility and may also be disabused of this if the outcome is not as they would wish:

*The other side of it is you can pop the bubble of the [formal] carer or the care coordinator cause they want them in [hospital] and you don't agree with that so they are left then supporting and trying to manage that with extra but they are still feeling that they are going round until you pop it and then you've popped their bubble, safety bubble if you will. (Nurse 01)*

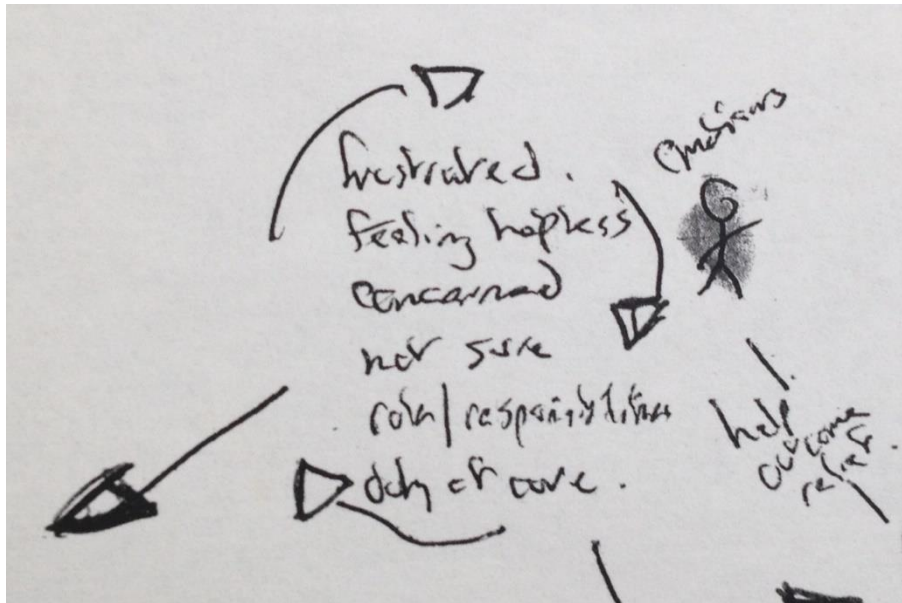


Figure 4.25 Excerpt of a Rich Picture placing role in a bubble.

### ***Dealing with reaction, expected and unexpected***

In addition to recognising the illusion of safety, or the bubbles people are in, the act of popping the bubble means having to deal with the reactions of having done so as the same participant goes on to describe:

*And then they're having, you are kind of outside that then. So for me it's kind of at some point you are going to pop one of these bubbles one of these revolving circles and get a reaction and that's then what you are left with dealing with.*

*(Nurse 01)*

Dealing with the reaction also involves dealing with the unexpected. The participant explains his reason for choosing to talk about a particular assessment, acknowledging that his choice of subject both in the interview and in the picture drawn had not been for him the usual experience:

*I'm calling it an incident, because it kind of evolved into something which was you know different than what I'd experienced. (Nurse 01)*

Recognising that he is recalling the “incident” because it is turned out unexpectedly, the participant at first describes what he would expect; the person being in a bubble, set apart or in an illusion of safety:

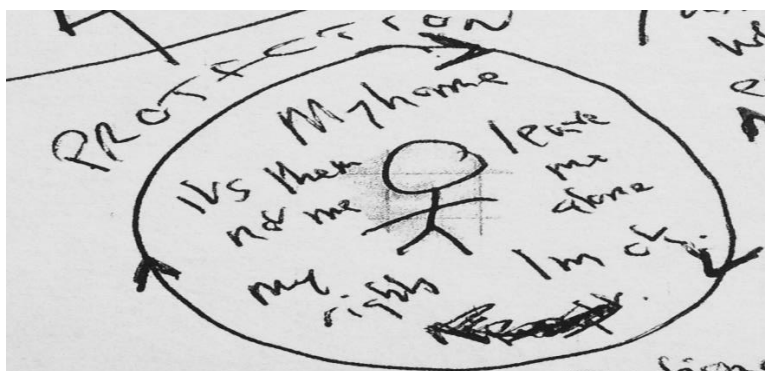


Figure 4.26 Excerpt of a Rich Picture showing person in a bubble.

*Everything's going great. Yes I like this, erm, so like I say, that was him in his bubble. (Nurse 01)*

The participant builds on the bubble idiom to explain the reality of the person's circumstances; that the house is not that of the person being assessed as the person was claiming but that of the parents. And so begins the process of disillusionment, or popping the bubble:

*It that's same kind of circle that bubble; looked at their [the parents'] emotions they are basically stating it is their home even though the service user was quite adamant it was his house. (Nurse 01)*

The participant reinforces this process of disillusioning the person and also illustrates this by drawing another bubble referring to the parents' situation:

*No, it's not it's the parents' property. (Nurse 01)*

He illustrates this in his picture:

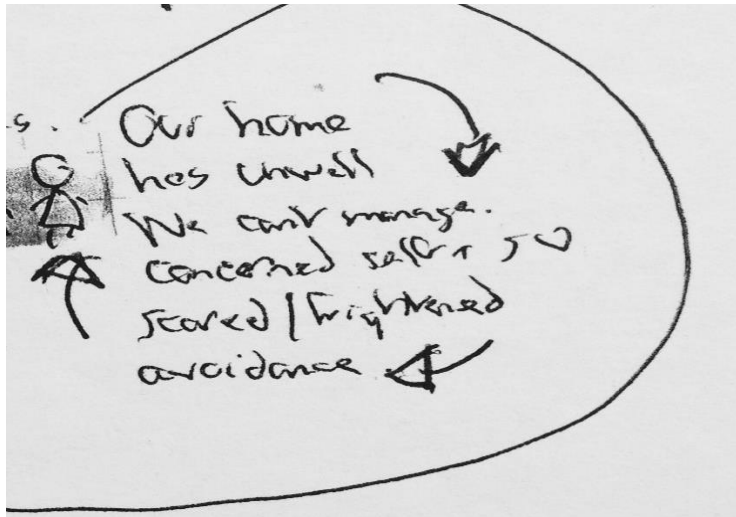


Figure 4.27 Excerpt of a Rich Picture depicting relative's bubble.

The person being assessed does not, according to the participant, accept what is being suggested insisting instead to be left alone. Moreover, the 'problem', according to the person being assessed, lies not with themselves but with others, in this instance the person's parents. In essence, the person being assessed is regarded by the participant as wishing to remain in their bubble and safe, so they believe, from being assessed:

*He was in his bubble again going round and round so it's his home, he's well, it's them not me, leave me alone, I've got my rights, it's my property I'm ok.*

*That's what I want. I'm not unwell. (Nurse 01)*

But, as required of approved mental health practice, the participant continues. The following section of the participant's picture outline the various elements involved including providing information about rights, assessing symptoms, risks and the possibility of violence, identifying if there is a plan in place, and seeking assistance from others, in this instance the police:

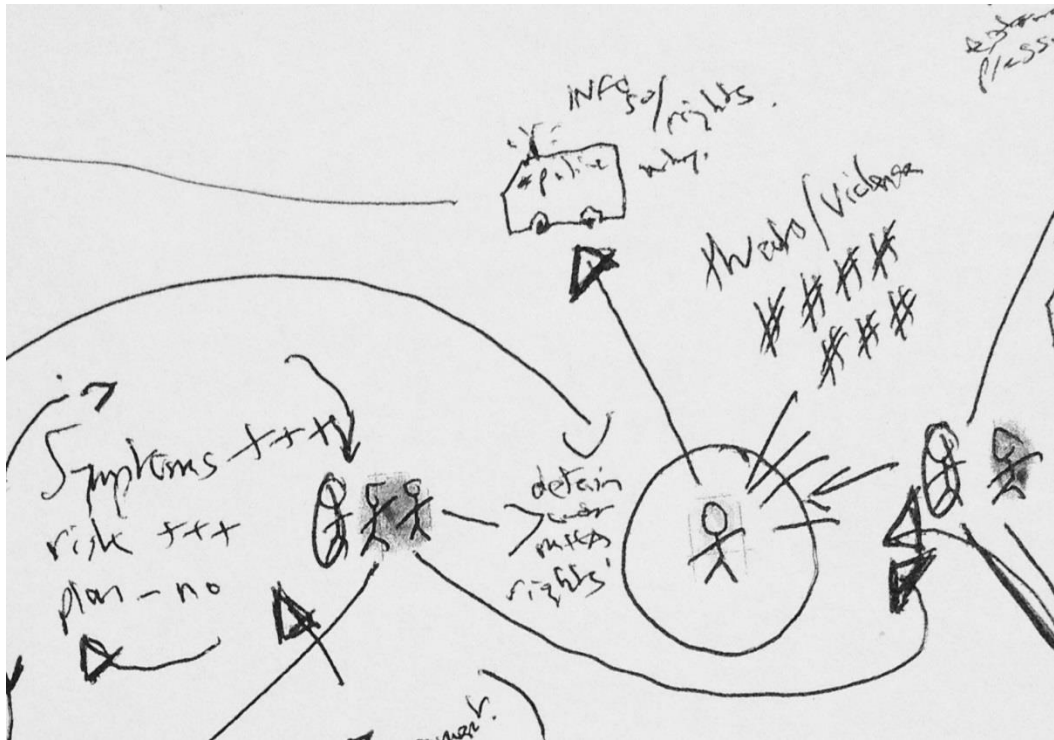


Figure 4.28 Excerpt of a Rich Picture showing aspects of an assessment.

The bubble metaphor also persists and is used to describe both the enactment of the assessment and the perspective of those involved. Here, all including the participant, are going around in what seem to be repetitious circles:

*He's [the service user] repeating his bit, we as a team assessing him, and then repeating our bit. So, again, its bubbles going round and round. (Nurse 01)*

The participant's whole picture shows this process. As he explains, "so now you've now got kind of four circles spinning:"

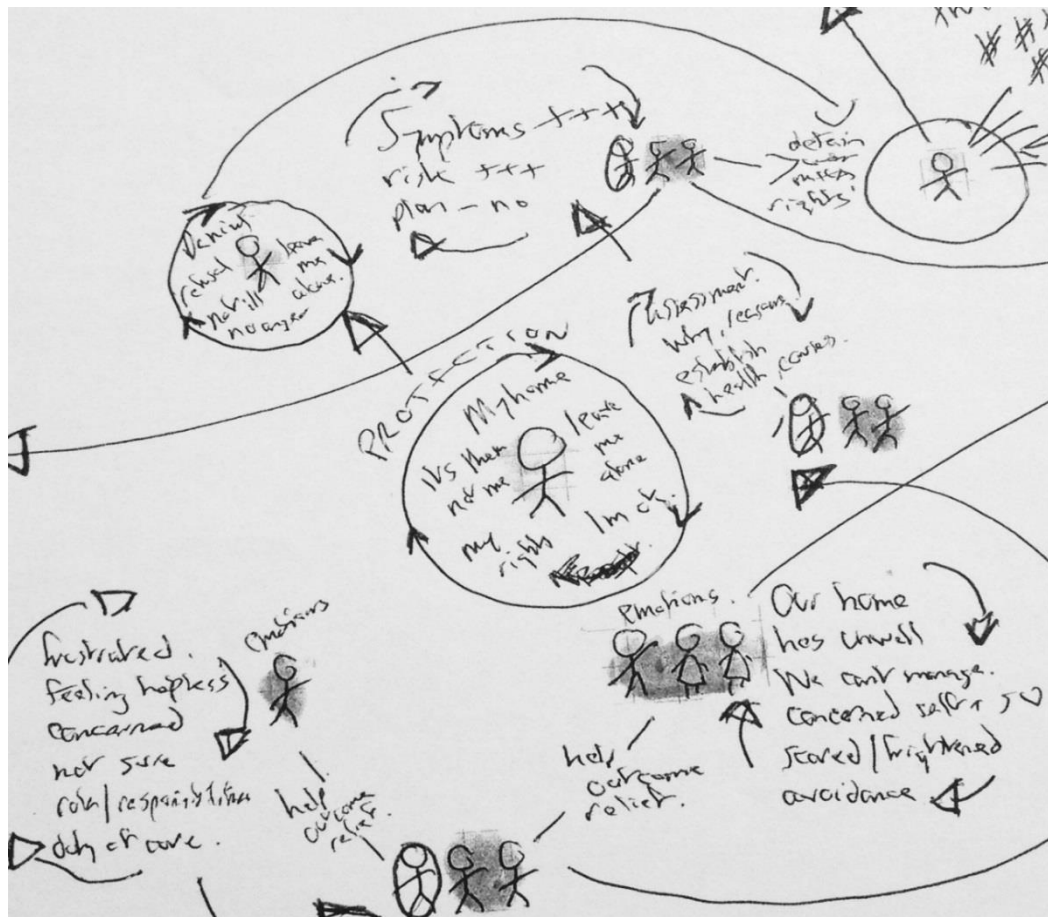


Figure 4.29 Whole Rich Picture showing circles spinning.

The person being assessed remains in his bubble under an illusion of safety while those around him, the participant, other professionals and the family are also all going around in circles:

*He was back to this circle if you will this bubble it's not me it's them. When you tried to suggest things and that the barriers would come up again. So again we are spinning again in another circle now. We have tried to go further and we are still going round and round. (Nurse 01)*

The person being assessed still refuses to accept what others are telling him:

*He repeated that. Nah, that's their issue not mine – it's nothing to do with me.*

*(Nurse 01)*

As the description of the assessment continues, the participant begins to describe the effect which enacting approved mental health practice has. In explaining to the person that he is there to consider an application to hospital the process of popping the bubble also continues. At first, the reaction of the person is calm, remaining in his bubble:

*So you then try and explain that, you know, from what you have said, you know, I feel now I need to make an application to take you into hospital and again gave him the reasons for that to which he said 'I'm not going'. So again he was sat there quite calm like, amenable, 'I'm not going'. (Nurse 01)*

But this calmness changes to expressed anger:

*He said, "I've told you I'm not fucking going" so, there was a change in his presentation from kind of being amenable to then this anger. (Nurse 01)*

Whilst the participant did not expect the anger nor the physical violence that follows he was, nonetheless able to anticipate the attempted hit:

*He got up out of the chair and said, "I've told you, I'm not fucking going," and come to hit me and it come up and again because I'm I don't know what it is ex nursing. I've worked on the wards and everything else but the body language I could see the clenched fist coming and I thought he's going to hit me so as he got up he come swinging at me but I was expecting it so I kind of ducked underneath and he clipped the top of my head. (Nurse 01)*

Popping the bubble or, undertaking approved mental health practice elicits a reaction but not in this instance, according to the participant, the expected or 'normal' one. The participant perceives a normal reaction to be when the person being assessed is informed that they are being detained they yield; "I'm going, I'm going." However, he is somewhat shocked by what for him is this unusual reaction. As he comments, he has experienced abuse before but not physical violence:

*You are thinking it really didn't need to be like this, erm, so again when I looked at it's a load of little bubbles going round and round and then we come in and pop one of these bubbles and we get a reaction. Ordinarily, I must admit, I've had reactions which have you know been normal I suppose: 'I'm going, I'm going'. You might get people who are a bit abusive but this was the first time I'd been faced with any kind of physical violence. (Nurse 01)*

The abnormal reaction continues when the participant describes what happened when the police were called to help because of the physical violence shown by the person being assessed. On this occasion not one, but many police cars arrived. It later transpired, but this was unknown to the participant at the time, that the house had been put under a special measure in anticipation of such incidents:

*I thought my God what is going on I looked at the ambulance staff and they looked at me, the family looked at me and he [the person being assessed] was you know screaming worse than ever and I'm thinking why do you know what I mean this isn't a normal. (Nurse 01)*



The chaos and sense of the unexpected deepens:

*I mean normally you get a car coming down or whatever. I mean I know it was an emergency call, but this was a bit extreme for that so again you know you've got bubbles for me now you are going around. I'm going around thinking where are we going you've got family there. Are we back to square one, what's going to happen and it's a bit chaotic. (Nurse 01)*

Approved mental health practice for this participant is about recognising the bubble, popping it and, ultimately, dealing with the reaction of having popped it either by having to detain the person or, in not detaining the person and returning the 'problem' back to the carers thereby popping their bubble. In both instances the bubble involves the illusion of safety for those in it:

*I mean you are popping someone's world right open now whether like I say that's the service user or that's the carers because they are not getting. In a way they are left with that popping there. Now you come here you've done nothing in their eyes. So at some point you are going to do that and you get a reaction like I say just this once they reacted where it was you know four fifteen minutes of chaos controlled chaos but I think some of that were a lot down to the service user as well how he reacted. (Nurse 01)*

### **Bubble equivalents**

Such 'bubble equivalents' are apparent elsewhere in the data but not always as obviously present. One social work participant (Social Worker 05) describes a particularly difficult assessment. From this participant's description the person being

assessed, just as in the first example, did not want to have help and wanted to be left alone. She illustrates this in her picture by also placing the person in a bubble:

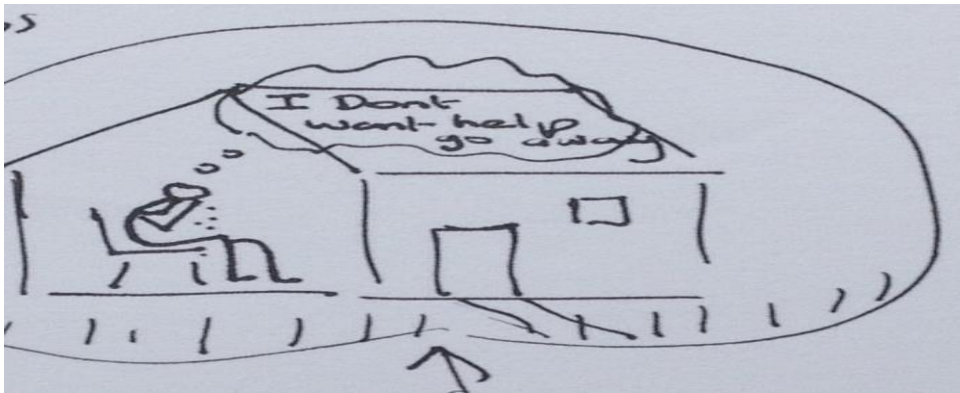


Figure 4.30 Excerpt of a Rich Picture placing person in a bubble.

But, also as is the case in the first description, approved mental health practice nonetheless continues. This time the reaction is as potentially physically dangerous as the first one:

*He maybe in his house but he needs support, the risks are evident to himself and to other people, he's taped up his letter box, he's attacked his brother with a Stanley knife, he's not eating very well and he's not sleeping very well and his bed's turned over and he's extremely distressed and he needs help but, you know there might have been help that was non-clinical, non-statutory he said to me when we went in he said to me when he went in, 'I can do this myself, there's nothing wrong with me I can cope fine, there's nothing wrong with me why are you all here?' (Social worker 05)*

On this occasion, the reaction is planned for:

*My concern about this man in the house is that nobody wanted to tell him we were coming and I was unhappy about that because of the situation with chasing*

*his brother, with him having a knife with his wiring his electric up, the door handles up to the electric they was saying no, and I had to agree well no, you're right and he was out all day in his car so we had to go first thing in the morning.*  
(Social Worker 05)

And the process of the assessment went according to the plan. This time the size of the police presence was expected:

*He did let us in, we didn't need to use a warrant he let us in but there were ten police officers because this was tactical aid so he was, so it was upsetting for him but, because there was this history that was the type of police there had to be, but they were very good, they let me take the lead, I was in control.* (Social Worker 05)

The participant repeats her sense of having controlled the situation and of the assessment being carried out as planned:

*But I really kept in control of everything and it went very, very smoothly the police said and from start to finish probably about an hour and a half which was really good going for the assessment, getting to hospital and on to the ward.*  
(Social Worker 05)

Despite this sense of control there was nonetheless an unexpected reaction from the person. This reaction, however, did not shake the participant's belief that the situation went as planned:

*When he got on to the ward then I had to, then I organised a Section 12 [of Mental Health Act] doctor to come and he was then beginning to get quite upset with me and in the end he launched his tooth brush and tooth paste and I'm fine*

*with that I sort of got out of the way really he got quite distressed, but I think it went quite as well as it could have done. (Social Worker 05)*

An occupational therapist describes an assessment where the bubble of the carers was popped. On this occasion, it was agreed that the person being assessed should be admitted as a result of perceived risk of harm to themselves:

*I think it was quite a caring approach really letting her explain what her worries were and what had been happening and listened to the family as well, their concerns. They were really at the end of their tether, stressed, really worried that she would take an overdose. (Occupational Therapist 02)*

The unhappiness on the part of the relatives is shown in her drawing:



Figure 4.31 Excerpt of a Rich Picture depicting relative's frustration.

When the decision to detain was made the person being assessed reacted, but passively, as the participant describes; *“she was compliant but not really agreeing”*.

*(Occupational Therapist 02)*

However, the lack of an available bed meant that the person was left waiting for an admission thereby, in effect, popping both bubbles:

*The family then were really angry and fed up erm so I was taking calls from them trying to explain, keep them informed erm trying to come up with some sort of contingency plan if there wasn't a bed anywhere in the country erm and sort of you know with the crisis team despite that in the end it got very late in the evening erm and I think the family agreed they would stay with her or take her back with them that night and in the end I went back the next morning a bed became available the next day and so she went there. (Occupational Therapist 02)*

The occupational therapist depicts the anger and lack of beds in this portion of her picture:

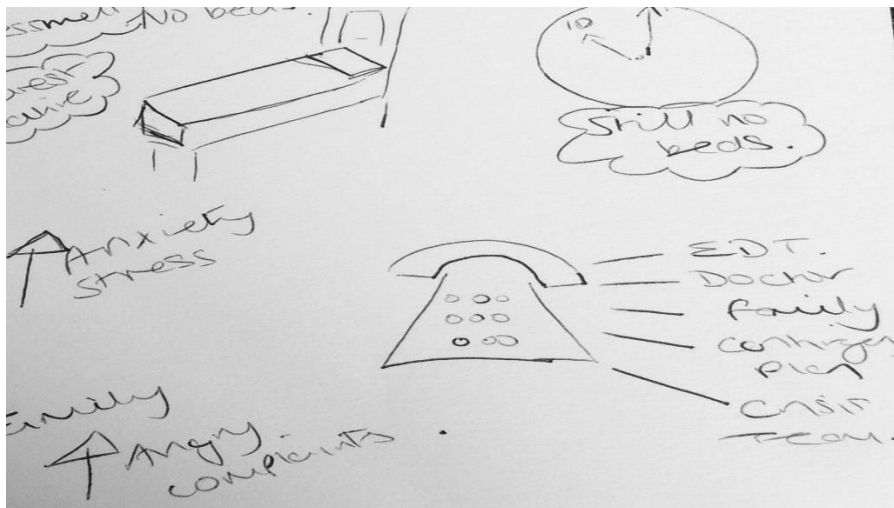


Figure 4.32 Excerpt of a Rich Picture showing lack of beds.

Dealing with the reaction of the person being assessed and of the carers does not just occur as a result of the process of assessment. It also occurs in the emotional display during the assessment. One social worker speaks of a situation where she had completed

an application to detain a male. He, in turn, expressed thanks to her for the way in which he had been treated. According to the social worker, he acknowledged and appreciated that she had listened to him and taken time:

*He actually said to me you know you've been a right star today and I thought I thought I've just put you on a section three [of Mental Health Act] you know and he said well you have because you've listened and you've let me sit with me girlfriend and you've taken time over and I appreciate that. (Social Worker 05)*

This reaction, the giving of positive emotion by the assessed to the assessor, is perhaps at odds with what might otherwise be expected in this situation; the person might understandably be angry at what had happened or, at the very least, not able to acknowledge it. This is of course the social worker herself saying this but she is clearly surprised at the unexpected, of being called a “right star” given the situation.

Another social work participant also describes vividly her own physical reaction during the process of carrying out an assessment:

*We went and we heard the dog. We heard the swearing the shouting, the doors being unlocked and literally, the door opened and the man and his dog flew at us like Superman and I was like he's not even on the floor. We three [colleagues] turned around and legged it and we ran and all I kept thinking was oh my God I've got a rucksack on what the hell have I worn a rucksack for he's going to get hold of me and drag me back and then we ran and ran and ran. (Social Worker 03)*

Nonetheless, the assessment had not been completed and the participant returned later to continue the process, this time with the police present to help deal with the reaction. She

again vividly describes her own emotional reaction while at the same time explaining how she tries to take into account what might be expected:

*I was shaken and scared that man shouldn't have been put through that. We shouldn't have been put through that and when I went back to see him when the police did come that afternoon my hands were in my pockets I was terrified I was terrified and, erm, I Just kept you know and it's wrong but I always say this and it's still in there what if he'd has a gun what if he has a knife what if his dog bites me. (Social Worker 03)*

She later explains that being physically scared is not usual either for her, or others. But, she is aware that, in approved mental health practice, practitioners have always to be mindful of the unexpected reaction:

*I'm not physically scared much erm you are mindful, you've always got to be mindful. I mean most people who've have been assaulted have said that they didn't see it coming or that it was an old person and they thought they wouldn't get attacked and they scratched the life out of them or something. So, I kind of think, be mindful, what if, what if, what if and always expect something and if you are aware of it that's all you can do isn't it? But I don't want to say that all people we assess under the Act are going to get us. (Social Worker 03)*

Being mindful of the “what ifs” and dealing with the unexpected is a usual part of the role, as another social work participant comments:

*It just happened. So it shows you why you've got to be on your toes you've got to be expecting the unexpected. (Social Worker 03)*

While, a second nurse participant echoes this:

*I mean I've been in this team for eight years and you can imagine the amount of different assessments I've done. That's not to say I'll do an assessment tomorrow that I've never come across. I stumble and I'll think God what I have got to do here. (Nurse 05)*

'Bubble equivalents' are also used to 'keep safe' or manage participants' own thoughts.

One social work participant explains that his thoughts are, in effect, managed bubbles as he explains:

*You know this is quite there's an awful lot going on up here in the head which is why we have got these bubbles. (Social Worker 01)*

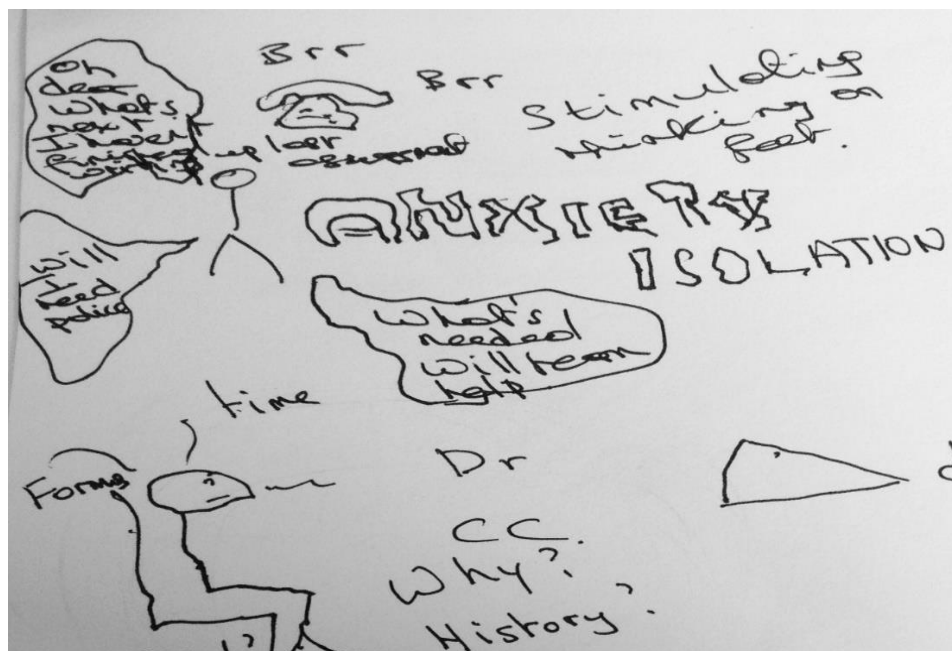


Figure 4.33 Excerpt of a Rich Picture illustrating keeping thoughts safe.

While another refers to the wish to be with her children, a reaction which she illustrates in her bubble picture:



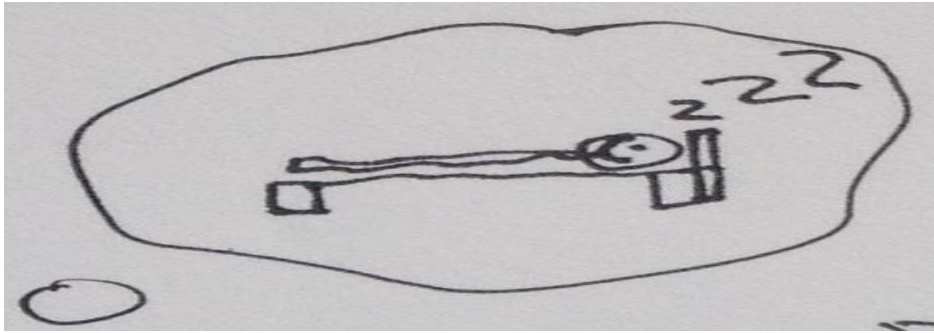


Figure 4.34: Excerpt of a Rich Picture depicting a dream bubble.

*that dream bubble is me thinking I'm tired, that's my children I don't see them because I've missed their bedtime and that's a big thing since I've had kids.*  
(Social Worker 03)

### *Summary*

Popping someone's bubble is an idiom used by one participant in this analysis to describe the enactment of approved mental health practice. For this participant bubbles represent what are in effect illusions of safety, both for the person being assessed and for those who are the person's formal or informal carer. The process of assessment begins by recognising what the bubble is, continues with the act of popping it and ends with dealing with the reaction when having done so. In the discussion by this participant, the physical reaction by the person being assessed to the process of popping of the bubble is an extreme one but not unique. Such 'bubble equivalents' are referred to elsewhere but by only a minority of participants. This is, instead an idiographic illustration of approved mental health practice. Emotional reaction is also found, both on the part of the assessed and the assessor and is reported by a range of participants. The reaction, then, is multi-dimensional. Dealing with these dimensions is a specific characteristic which participants from all professional backgrounds attribute to approved mental health practice.

## **Conclusion to the chapter**

The first theme in this analysis shows that approved mental health practice, while clearly understood by all participants as a legally determined one with set procedures, is also shown to be undetermined in both its straightforwardness and complexity. The assessment process has a number of stages but not all are undertaken in a linear manner. Such indistinctiveness is encapsulated in the conflation of assessment and interview, the latter is actually one stage but on occasion is merged with the process as a whole when participants use the same terminology, assessment, for both. Other discrepancies occur; participants report causing, or being subject to discomfort, whilst at the same time attempting to achieve balance. They also hold or 'take' situations and emotions yet 'give back' when this is deemed the 'right thing' to do. On the one hand, "smoothing", the act of seeking alternatives or not making an application for detention is a core consideration, and seen as positive risk-taking. On the other hand, feeling obliged to obtain a hospital bed wavers and, when carried out, is done despite this being a determined responsibility of others. This is at the same time contrary but 'smoothing'. Last, seeking wider services, despite having little control over their provision or allocation, is the ultimate indeterminate. No differences were observed in participants' accounts that could be associated with their professional background, gender or longevity. The picture was uniform and the same features identified albeit they were expressed in slightly different ways.

Abandonment and 'sabotage,' as it is being termed, are themes which appear throughout the data and is the focus of the second theme in this chapter. Abandonment by doctors takes place during the assessment process. It also is reported as occurring before and is, in essence, sabotage. Whilst there is no evidence in this data that participants abandon doctors during assessments there is nonetheless growing signs of sabotage towards

doctors during assessments. Such sabotage is on a continuum. For some participants it is used to assert role boundaries, for others it is used as a sign of the increased equality of the professional relationship between the doctor and the approved mental health act practitioner. For one participant sabotage means relinquishing the traditional, in other words deferential, relationship between the nurse and the doctor and ultimately the rejection of psychiatry as it is traditionally practiced.

In the third theme, participants demonstrate the theory of personhood with the recognition of and respect for the person. The realisation of putting this theory, personhood, into practice is specifically mentioned by one participant, a social worker but it is present throughout the data and from the range of participants. This process is praxis, a fundamental finding. Moreover, a moral concern for others is demonstrated. When embodied in practice such praxis is used to defend the individual but also is applied in defence of carrying out approved mental health practice and characterising its significance.

At first, the fourth section of this analysis shows that participants, nurses, social workers and occupational therapists alike, both male and female, and irrespective of longevity, experience anxiety and fear and the potentially harmful impact of dealing with risk or conflict when undertaking approved mental health practice. However, they also at the same time experience a range of positive emotions, sometimes in direct contradiction. There is again no difference noted according to attribute. In reflecting on their role, these seemingly contrasting emotions co-exist for participants who also use them to control their approved mental health practice as they 'stand back', or 'hover over'. The use of contrasting and sometimes conflicting emotion by the individual is a way of allowing not being in control but also, simultaneously, using their presence to be in control. Both aspects constitute a significant and deliberate use of emotion during

approved mental health practice involving, not just the existence of contrasting emotions, but the use of them. Referred to as “pull” in this analysis, the active use of dissonance is a fundamental aspect of how participants experience approved mental health practice.

For nurse participants in this study as discussed in the fifth theme in this chapter, undertaking approved mental health practice is experienced as moving from being typical to atypical nurses or, in their own words, “unclean” to “honorary social workers”. By putting a name on value driven considerations such as human rights and least restriction they describe attributes which, whilst present in nursing, are not, according to them, at the forefront. To begin, nurse participants discuss convergence; a belief there is a generic mental health professional role undertaken in the same way irrespective of professional background. However, in making sense of their experiences as approved mental health practitioners the nurse participants in this analysis report the need to overcome difference adopting a professional perspective perceived as more akin to social work. The praxis of approved mental health practice therefore influences professional identity. When undertaking approved mental health practice nurses challenge traditional medical processes both in the way in which an interview is conducted and in the professional perspective which they bring. But, also reported is a questioning of approved mental health practice. The former is a change to the deference hitherto shown by nurses to doctors and is fundamental to undertaking approved mental health practice; for nurses, approved mental health practice is also a new way of working. The latter is also a challenge to ‘normal’ approved mental health practice and may represent a new way of working for all approved mental health act practitioners.

Throughout the data in the final section of the analysis, there are descriptions of assessments by a range of participants which elicit reactions; from the person being

assessed, from carers and from the person assessing. Such reactions are physical and emotional and, on occasion, extreme and unexpected. They are likened by one nurse participant to popping someone's bubble whereby an unrealistic sense of safety is disabused by the process of assessment. Other participants from a range of professional backgrounds, but not all participants, also refer to 'bubble equivalents' to describe safety, or the illusion thereof, and the reaction that occurs once the bubble is popped. There is an awareness that expecting the unexpected is also an aspect of approved mental health practice. Popping the bubble and dealing with the multi-dimensional reactions of having done so is a key attribute.

## CHAPTER FIVE

### Discussion

#### Introduction to the chapter

This research set out with the overall aim of understanding what impact, if any, professional background has on approved mental health practice and how it is experienced. The participants are drawn from currently practicing Approved Mental Health Professionals, the one incarnation of approved mental health practice in the United Kingdom that is now extended to other non-medical mental health professionals. The initial objective, as detailed in Chapter One, was to explore perceptions of the role and the influence of professional identity on approved mental health practice. A second was to determine and understand professional identities as internalised and applied in approved mental health practice including in relation to attributes such as skills and values. The last was to examine any emotional and psychological aspects involved in undertaking approved mental health practice from each research participant's perspective, including practitioners' self-esteem and aspirations.

This chapter discusses the findings of the research in light of pre-existing evidence and relevant theoretical frameworks, and is made up of two parts, the role in practice and the role in praxis. The combination of findings addresses the fundamental concern about professional background demonstrating that this only matters in some respects.

The synergy between *the role in practice* and *the role in praxis* underpins the discussion throughout, encapsulating the moral aspects of approved mental health practice and the enactment of them. Approved mental health practice is shown to be both a matter of instrumental actions and a process underpinned with a common framework or moral imperative, aspects of which are a theoretical stance only. Others aspects are found and

enacted on reflection by the participant. Last approved mental health practice is shown to involve sophisticated emotion management in the workplace.

## **The role in practice**

### ***The belief and the challenge***

As mentioned in the introduction to this thesis, approved mental health practice was extended to mental health workers from professional backgrounds other than social work in the belief that, with similar training, these workers would be equally able to undertake the role. Approved mental health practice includes dealing with any social and domestic elements and is combined with the moral aspect of making decisions based on a non-medical alternative to a hospital admission. This approach is known collectively as the social perspective, the upholding of which is the generally accepted rationale for approved mental health practice. This premise underpins current regulations (Health and Care Professions Council, 2013) and is also echoed in the attitudes expressed in much of the existing literature (for example Davidson and Campbell, 2010, Rapaport, 2006, Matthews et al., 2014). As previously summarised in Chapter Two, research commissioned in the light of the suggestion to open-up approved mental health practice to non-medical professionals other than social workers, proposes that the function of ‘social work’ should be retained (Quirk et al., 2000 p 9). This function embodies consideration of, and dealing with, social and domestic circumstances. In addition, because there is strong evidence of a relationship between being detained under mental health legislation and being socially disadvantaged (Hatfield, 2008, Hatfield et al., 1992, Hatfield et al., 1997, Hatfield and Antciffe, 2001), approved mental health practitioners need to both understand the association and provide a different perspective (Hatfield, 2008).

There are two main developments which have previously associated the profession of social work with the social perspective and to some extent continue today. First, that the practical or instrumental functions required of approved mental health practice mirror the traditional social work ones such as assessment, co-ordination, inter-professional working and advocacy. Second that social workers bring a different moral perspective given that they are trained in the social sciences (Hatfield, 2008 p1555, National Institute for Mental Health in England, 2008 p.30). Yet, the evidence from this current study finds that treating as synonymous the skills required of approved mental health practitioners with those of professional social work is inherently contradictory. This finding mirrors a previous, yet mostly forgotten, theoretical viewpoint which argues that approved mental health practice cannot be accomplished as originally envisaged (Prior, 1992). Consistent with this idea and building on it, the current study shows that the social perspective of approved mental health practice is only partially fulfilled. Ironically other responsibilities, not those of approved mental health practice, are undertaken during the process and are carried out irrespective of professional background. This section of the chapter goes on to discuss such “smoothing” as it is termed, but first examines the required skills and social perspective in more detail.

### ***Instrumental aspects***

There is a strong agreement in the empirical literature as to the requirements of approved mental health practice (Quirk et al., 2000). The current study produced results which corroborate the findings of a great deal of this previous work as evidenced in the analysis theme ‘being determined and undetermined’ (see Chapter Four pages 107-126). Throughout this theme, specific processes associated with approved mental health practice, or *the role in practice*, are shown as commonly carried out irrespective of professional background and is of particular note given the original aim of the research.



Participants undertake what is a legally determined, non-medical role with set procedures and one which is also shown to be otherwise undetermined in that it is experienced as both straightforward and complex simultaneously. This process involves a number of stages, described in what follows in a linear way, but not all undertaken sequentially and is: the taking of a referral and information gathering; undertaking the interview and making a decision; enabling conveyance if the decision is to detain and last, recording what has happened. This particular finding is consistent with previous research which categorised the process as the build up to the assessment, the assessment and the aftermath (Quirk et al., 2000).

As also shown in ‘being determined and undetermined,’ a range of participants in this study engage in various generic skills including juggling numerous components, managing time pressures, provoking or being exposed to discomfort whilst at the same time balancing the needs and safety of the person with the needs and safety of others. Once more, the identification of these skills and functions, including the tension that can arise between them, is in agreement with studies conducted previously (Quirk et al., 2000, Bowers, et al., 2003). However, the ability *simultaneously* to understand cognitively and manage emotionally the elements of approved mental health practice is shown to be an important attribute for practitioners. Balancing disparate elements is a new appreciation of the role in practice, the presence of which is a consistent thread and, as is later discussed, its active use is a fundamental element of approved mental health practice and a new finding in this thesis.

### ***The social perspective***

Previous studies are inconsistent as to whether the functions or skills of approved mental health practice are specific to the profession of social work. Nor is there

evidence in the literature review in Chapter Two to support or refute the claim that any profession is best suited to undertake it. Moreover, in the context of integration a convergence in roles may be one potential explanation that approved mental health practice can be performed by any professional group.

As has been seen, an early finding in this study supports a previous proposition that the instrumental role of approved mental health practice need not necessarily be the remit of a particular profession (Quirk et al., 2000). The findings of this study do not, however, concur with the additional suggestion that the skills needed to undertake approved mental health practice might be difficult to replicate by other professions (Quirk et al., 2000). What also surfaces and is of further interest is that, on occasion, the ‘social work’ function and approved mental health practice function intermingle, thereby replicating the earlier conflation of ‘social work’ and the profession of social work. This finding is best illustrated when participants from each of the professional backgrounds use the term “interview”, which is one part of the process, when they actually mean the assessment as a whole (see Chapter Four). One explanation for this use might simply be that participants do so as a shorthand reference. Alternatively, and as is argued here, this coalescence may be an indication that the functions intermingle and importantly that they are not carried out as is theoretically anticipated, *regardless* of professional background. Rather they are carried out *in common* as approved mental health practitioners. This particular viewpoint is strengthened when the expected ‘social work’ functions and other requirements of approved mental health practice are examined in more detail.

As has been seen, approved mental health practice, or *the role in practice*, as experienced by participants in the first theme of the data analysis is reported consistently (see Chapter Four pages 104-123). Irrespective of professional background,

gender or longevity, participants describe uniform characteristics and behaviour which, as the title of the theme suggests, coexist. This juxtaposition is shown by the role being described and experienced as straightforward yet complex, in which participants aim for balance *and* discomfort; both are identified as requirements to do the role well. This give and take is a further illustration of the holding at the same time by participants the disparate elements of approved mental health practice, a repeat theme of this discussion. As suggested by the conflation of the terms interview and assessment, a separate interpretation also emerges. Namely, that there is a partial completion of the role. In the theme entitled ‘being determined and undetermined,’ a last and crucial indeterminate is found; that some participants repeatedly undertake “smoothing,” a phrase used by one participant to describe the process of obtaining a hospital bed and doing so in the absence of any social alternative. This tendency is found across the various professional groups and does not belong to any one in particular. This is a finding that fundamentally casts doubt even on the relevance of the initial question of this thesis. It ultimately suggests misgivings about the core purpose of approved mental health practice or indeed the impact that professional background might have, thereby echoing concerns voiced when the role was originally conceived (Bean, 1980, Brown, 2002).

### ***“Smoothing”***

Long-standing policy (Health and Social Care Professions Council, 2013) and theoretical (for example, Rapaport, 2006) stances continue to place the social perspective at the heart of approved mental health practice. However, the term “smoothing” or, in the particular instance to which it refers in this study, the seeking of a hospital bed in the absence of social alternatives, indicates an ironic fulfilment of approved mental health practice and its inherent contradiction. Approved mental health practice in effect melds with other ‘non-approved’ mental health practice work.

Whether social worker by professional background or not, participants are seen to align to the moral framework or theory of the social perspective but only on rare occasions can they use a social alternative in practice. The social perspective is, therefore, partially implemented at best. This perspective, conflated with social alternatives, or the lack thereof, indicates two things. First, it is a replication of the amalgamation of social with approved mental health practice and not that it is a social work role as such. Second, approved mental health practice cannot enact the moral framework as commonly believed. This viewpoint is revived empirically through this current research but is not a new one, albeit it has been mostly forgotten. It was also originally offered as a perspective when social workers alone fulfilled approved mental health practice. That this outcome applies currently, even as the professional identities of those involved has expanded, will now be explored in more detail.

Discussed during the early days of the implementation of one incarnation of approved mental health practice, the Approved Social Worker, one commentator argued that its accomplishment was not possible since few, if any, social alternatives were available (Prior 1992). Prior concluded that the assumption that there is an alternative social model of care and treatment and upon which the [approved mental health practice] role rested was therefore inherently contradictory (Prior 1992 p 106). This finding was later mirrored in another research study and on that occasion reported as surprising. In response to a question about what was felt to be the most important aspects of approved mental health practice, fewer than one-third of participants mentioned bringing the social perspective to the assessment (Gregor, 2010 p. 437). This present study, therefore, builds on already existing conclusions which are that the social perspective is an abstract concept. Just as interview and assessment are conflated to suggest a partial

undertaking of the role, so too does the consideration of the social perspective become necessarily diluted in the light of the practical reality of few social alternatives.

This broader contradiction is of relevance to this thesis. The dilemma posed is that if the purpose of the social perspective is to challenge the dominant medical determinants of mental ill health, why then do the attributes of those detained under mental health legislation ironically mostly epitomise those from socially disadvantaged backgrounds, as one commentator queries (Campbell, 2010). That there is a correlation between social disadvantage and detention is extensively evidenced (Hatfield, 2008, Hatfield et al., 1992, Hatfield et al., 1997, Hatfield and Antciffe, 2001). This question remains unanswered in the current study. Participants in practice either ‘do’ hospital admission or ‘do not’ sign the “pink (admission) papers”. That the social perspective is continually championed and moreover viewed by some as the element most associated with the profession of social work is, therefore, a dual distraction. It mistakenly fuels the belief that there can be any profession best suited for approved mental health practice. As vividly demonstrated in a picture drawn by one participant of a crumbling wall (see Chapter Four page 123), social alternatives are rarely available and rarely used. The social perspective is rather a theoretical stance which, even if present in participants’ thinking, is mostly absent in their doing and it is suggested an aspirational goal only.

The notion that a particular profession can fulfil the social perspective of approved mental health practice is an underpinning supposition for this study. So far, as we have seen, this particular hypothesis is not substantiated. It is likely that the viewpoint which equates the profession of social work alone as being the profession best suited to uphold the social perspective cannot be borne out in reality. Moreover, the term “smoothing” means, paradoxically, that approved mental health practitioners of all backgrounds take on a responsibility which is otherwise that of the doctor, the most notable example in

this study being the responsibility of obtaining a hospital bed. Availability of contemporary psychiatric inpatient beds is problematic. Finding one can take time and is perceived as a menial task. But, as will be shown, in ‘allowing’ approved mental health practitioners of all professional backgrounds to accomplish what might be perceived as a menial role, doctors also exhibit behaviour which could be viewed as morally dirty. This chapter now goes on to consider this dimension, an unanticipated finding but one which adds to the understanding of the moral framework of approved mental health practice and is an example of how it, and the significance of the role, is defended. This chapter will now discuss the findings through the constructs of clean and dirty.

### ***Clean and dirty***

Having considered the social perspective, a hitherto significant and widely accepted element of the moral framework of approved mental health practice, this discussion now turns to a suggested second component. As evidenced when one nurse refers to their approved mental health practice as moving from “unclean” (see Chapter Four pages 171-174) and also when doctors are shown to end their involvement in approved mental health practice at the point when they believe their particular role is over (see Chapter Four pages 128 - 134) the second aspect of the moral framework is found, an unanticipated finding in this study. This will be discussed using the theoretical constructs of clean and dirty after Douglas (1966) and Lizardo (2012) and also through the lens of the sociological concept of dirty work as applied to a number of research studies concerning mental health occupations (Hughes 1971, Emerson and Pollner, 1976, Brown, 1989, Morriss 2014, 2015).

The use of the term dirty as a conceptual metaphor was first introduced by anthropologist Mary Douglas (1966) who, based on her observations of different understandings of hygiene and the avoidance of dirt between European and so-called primitive cultures, together with knowledge of the causes of disease, proposed that dirt is “matter out of place” and clean is “ordered arrangement” (Douglas, 1966 p 36). The concepts, therefore, are culturally bound but used in this context to signify that more morally sound elements are clean compared with less morally sound ones that are dirty. These binary constructs are later said to constitute a cognitive model for understanding actions in the moral domain (Lizardo, 2012). When applied to occupations, there is long-standing sociological theory concerning their nature, so-called dirty work (Hughes, 1971), which contends that every occupation contains various activities, some of which are less desirable or by implication less moral. According to this same theory, in some occupations workers are practically compelled to play a morally shameful or dirty role and moreover, that there are ambiguities and apparent contradictions in the combination of duties including many psychiatric practices (Hughes, 1971).

Some have explored workers’ experience using this theoretical basis and found that participants labelled their work as dirty when they feel compelled to do something *to* a person in a coercive sense, such as having to arrange a psychiatric inpatient admission (Emerson and Pollner, 1976). Here, workers who believed that their occupation was therapeutic in orientation also had to contend with people they perceived as not needing that therapy and characterised the *‘doing for’* as therapeutic (clean) whilst the *‘doing to’* as dirty but justified. So, in the designation of the coercive element of psychiatric occupation as dirty work, the worker is declaring a moral distance (Emerson and Pollner, 1976). In a later study, most participants designated non-psychiatric tasks as dirty. In other words, those participants were gatekeeping elements viewed as ‘beneath’

their therapeutic skills or dirty and in which again therapeutic work was distinguished as clean (Brown, 1989). A more recent exploration of dirty work has been applied in which it was argued that there are myriad elements to approved mental health practice where social workers undertaking it viewed the work as high status and prestigious and that participants did not simply designate it as dirty (Morriss, 2014, 2015). This finding echoes Hughes' assertion that dirty work is somehow integrated into the whole and also into the prestigious role of the person who does the work. In effect, ascription of a role as special or elevated launders dirty work into that which is perceived as clean.

Approved mental health practice could be said to equate with dirty work in that it is a role in which the practitioner is required to undertake ostensibly a less desirable and arguably morally difficult activity when having to make a decision about whether or not to detain a person and act upon it, sometimes against that person's will. However, the role, whilst a statutory duty, is one which participants put themselves forward to undertake and for which they undergo additional and specialist training. It is not then truly undesirable in terms of motivation but could arguably be viewed as such in the doing of it. However, no participant in this study referred to the coercive element as '*doing to*' neither did they view this aspect as beneath them or a lost opportunity to engage in therapeutic work or '*doing for*'. Interestingly, when approved mental health practice was opened-up to nurses, one of the early fears was that this might impact negatively on the therapeutic relationship with patients. One study into this possibility is inconclusive (Bowers et al., 2003) while a second found little evidence that this is the case (Hurley and Linsley, 2007). Nor is this suggestion borne out in the present study. Instead, participants, as shown in each theme of the analysis concur, in part, with Morriss' conclusion that participants perceive the role as a complex and powerful one



involving potentially serious consequences for the person subject to the assessment but also as prestigious (Morriss, 2015).

Participants also demonstrate the cognitive and affective capacity to make a morally challenging decision, however contradictory. So, even though approved mental health practice might be considered an occupation which has aspects of being dirty in that a morally challenging decision has to be made, participants in this study do not distance themselves from it, as Emerson and Pollner (1976) might argue. Instead, as seen in the analysis theme “‘pull’: the active use of dissonance,” (Chapter Four pages 157 - 161) participants choose deliberately to employ cognitive and emotional distance as a way of dealing with the ambiguities and contradictions in psychiatric work, rather than to eradicate or ignore (Hughes, 1971). The idiographic interpretation of the Emerson and Pollner study (1976) sits well with the philosophical underpinning of this thesis since it too is considering the meaning of approved mental health practice for individuals in a particular context. As such, and in line with this methodological approach, there are a number of singular experiences present in this current study which, on interpretation, provide meaning in relation to dirty work. So, in ostensibly moving from being “unclean”, nurses are perceiving approved mental health practice as morally determined, or clean. To use the analogy, there is an understanding that whilst the role may be challenging and include aspects of dirt, undertaking it is a morally clean act; a conclusion that fits with the distinctions discussed earlier between research in practice and research in praxis. The practice might be dirty but the praxis is clean. The active management of this moral contradiction provides valuable insight into how approved mental health practice is accomplished irrespective of professional background.

Also encapsulated in the theory of dirty work is the categorisation of characteristics and behaviour whereby those with perceived higher status and professional standing are said

to concentrate on the most desired or morally sound roles of their occupation, whilst at the same time transferring the less morally sound or stigmatising work to others with lower standing (Hughes, 1971). Approved mental health practice mostly takes place within a health setting in which a doctor is traditionally seen as 'being at the top' of an institutional hierarchy and others such as nurses, occupational therapists and social workers 'underneath'. In this particular understanding of dirty work, division of labour then is based on hierarchy and concerns the relation between the clean-ness of characteristics and behaviour and their dirty-ness. Hughes is also interested in the frontier or boundary between occupations, in this instance a doctor and a nurse and in particular how such boundaries are as he terms resorted (Hughes 1971, p.314), or rearranged. This section of the chapter now considers these aspects in relation to the findings.

In another extension of the dirty work analogy, doctors are seen again in the analysis theme 'unclean to honorary social workers' (Chapter Four pages 165 - 179) to shift the dirty; behaviour which is being blocked, primarily by approved mental health practitioners who in this study are nurses by professional background. This is of particular interest in the context of this research since the expectation might otherwise be that it would be social workers who would more 'naturally' do such blocking. A factor often put forward as a fundamental flaw in the opening up of approved mental health practice to professions such as nurses and occupational therapists is the possible impact of hierarchical deference from nurses to doctors. Doubters argue that nurses in particular will defer to, rather than challenge, a doctor (Haynes, 1990, Quirk et al., 2000, Walton, 2000). For nurse participants in this study there is evidence that, when undertaking approved mental health practice, there is a resorting of the traditional nurse-doctor boundary. When undertaking approved mental health practice nurses challenge

traditional medical processes, for example in the way in which an interview is conducted; when undertaking the role previously the doctor would have been seen to take the lead. Also, in the professional perspective they bring as approved mental health practitioners, nurses speak of aspects associated with the social perspective, ones which hitherto had not been foregrounded in their practice. Nurse participants make sense of what they do as approved mental health practitioners by defending the role and blocking the dirty when it is sent from elsewhere. In so doing, nurses also challenge the way in which approved mental health practice is accomplished, as also reported is a questioning by them of how approved mental health practice is carried out. The former is a change to the deference hitherto shown by nurses to doctors and for them demonstrates that approved mental health practice is also a new way of working. The latter also constitutes a challenge to customary approved mental health practice and may represent a new way of working for all approved mental health act practitioners.

Other, particularly unambiguous examples of the elements which could be said to equate with the theory of dirty work are found in this research. There are consistent reports of abandonment or “role over” (Chapter Four 128 - 133) in which a doctor will leave an assessment as soon as they perceive their professional input to be complete, notwithstanding the difficult situations which pertain, nor indeed the physical danger a ‘lesser’ colleague may be in. Consistency of description occurs when participants from each professional background discuss their perception of the doctor’s role during approved mental health practice as arises in the analysis theme ‘abandonment and sabotage’ and is commonly characterised, and also expected, as such. It could be argued that, as it is the recognised responsibility of the approved mental health practitioner and not the doctor to ensure that the assessment is completed (Department of Health, 2015), such behaviour is professionally legitimate or clean. However, that one profession can

abandon another could also be viewed as morally illegitimate since one profession possibly perceiving itself of a higher standing is seemingly willing to avoid the dirt or perhaps have a less sophisticated understanding of the difference between work that is dirty and action that might be clean in dealing with that work. As is also shown, no participant in the analysis abandoned doctors during assessments. This uniform reference from participants of each professional background to being abandoned by doctors at a certain point in the assessment also occurs in some instances even before the assessment has started. This sabotage, as it is termed in the analysis, (Chapter Four 128 -134) is, therefore, present both before and during the process. But, sabotage also happen in reverse. For example, again in the analysis theme ‘abandonment and sabotage’ one nurse refused to complete the administrative forms required of the doctor despite being asked to do so by them, presumably, as their inferior. Both the doctor and the nurse perceived this activity as menial, or dirty, but on this occasion the nurse was adamant that she would not do it and was proud that she had refused. The profession that might otherwise be seen as of lesser professional standing on this occasion is shown to be stopping the shifting of the dirt. This act of resistance of itself becomes clean and interestingly mirrors the metaphor of coming clean, or its meaning telling the truth.

At first, it could be argued that the thesis, which suggests that some occupations in approved mental health practice would defer to doctors, seems plausible. However, such fears do not seem to have been borne out according to the stopping of the shift of the dirt found here. The binary concepts of dirty and clean form a moral framework underpinning the occupation of approved mental health practice. They also indicate that approved mental health practice involves the holding of both clean and dirty, opposing constructs which underpin a moral framework present within approved mental health practice. This is a further illustration of the thread regarding the active use of disparate

elements which runs throughout this discussion and which provide valuable insights into how the role is accomplished. This process is also an initial indication of the relationship between the *role in practice* and the *role in praxis* whereby the morally based theory of dirty work is realised on reflection and applied in practice. This thesis proposes that while the role in practice may be dirty, the enactment of it transforms so that the role in praxis is clean. This relationship, and other interpretations of it emerge throughout. It is to a focus on the latter that this discussion now turns.

### **The role in praxis**

So far, this discussion has demonstrated the instrumental aspects of approved mental health practice. It has also discussed its moral imperative, one already established and questioned, the social perspective. Another, clean and dirty, that echoes to some extent findings in other research studies, albeit the management of the contradiction is new. The second part of this chapter continues to address the fundamental concern of this research about professional background through the findings which have demonstrated that its impact is marginal. It will discuss why this might be the case drawing on the literature of personhood and emotion management in the workplace. To do so it turns to *the role in praxis* and discusses findings that represent both a shift from the original aim of this study and which demonstrate that approved mental health practice is not just a matter of instrumental actions underpinned with a common framework or moral imperative, but is rather a synergy of both.

Praxis is a key concept encapsulating both the conscious and unconscious understanding of a theory and the moral enactment of it in practice, but realised as such on reflection and not, as is sometimes used, simply a meeting or melding of theory and practice. As used here, praxis refers to sense-making both cognitively and affectively in the mind

and putting this into practice through the body (en-acted). As a philosophical concept, praxis has undergone a number of iterations. The original Aristotelian view is that praxis refers to the human endeavour of thoughtful moral action (in Gray and Lovatt, 2007). Later proponents such as (Arendt, 1958), viewed praxis as the interpersonal activity by people that seeks to balance meaningless instrumental activities with those that are morally sound. Friere (1972) identified praxis as the coming together of action and reflection in the human body and mind and also as a concept in which emancipation is integral. When applied to so-called practice disciplines, praxis ranges from conceptions of what constitutes, for example nursing or social work theory, the interconnection between such theory and practice, and the development of reflection on practice which produces understanding and action (Schon, 1983). Integral to the Aristotelian view of praxis is the notion of phronesis, sometimes referred to as practice wisdom, or a process of moral reasoning. In addition, good action or practice accords with phronesis and is known as eupraxia. This research demonstrates praxis as it is defined here in two ways. The first occurs when, on reflection, participants makes sense of and enact a moral theory, in this instance personhood. The second that the praxis of approved mental health practice influences professional identity. Albeit unwittingly, others have discussed praxis as it relates to approved mental health practice, in this instance the principle of last resort whereby crisis intervention theory or the understanding that an intervention in a crisis situation is of itself therapeutic might on occasion obviate the need for hospital admission (Quirk et al., 2000 pp. 47-48) but, no connection is made in that instance that this was evidence of praxis nor was there a understanding of the use of personhood as a fundamental aspect of approved mental health practice.

## ***Personhood***

When accomplishing approved mental health practice and in their reflection on it, participants, as shown in the analysis section ‘praxis’ (Chapter Four pp. 141-157) were found to have understood that they had enacted theory, the most prominent of which in this study is personhood, the notion that the person is not only, or defined by, mind and thought but the person is also evident as action through the embodied self (Kitwood, 1997). Such a perspective is the antithesis of the Cartesian dualism between mind and body as separate entities with the essence of humanity and individuality of the person residing in the mind. Personhood is a key idea in the field of dementia and is increasingly being applied outside of gerontology. It forms the contested basis for person-centred care in nursing (McCormack, 2004) and more recently is being aligned with approaches such as relational social work (Raineri and Cabiati, 2015). Kitwood, the progenitor of personhood with respect to dementia, challenged the notion that dementia is simply a neurological process or a medical condition. In particular, he did not agree that loss of self, which is commonly attributed to people who suffer confusion in dementia, happens as a consequence of loss of functions of the mind. Instead, Kitwood asserts that fundamentally a core self remains intact and evidenced through different channels (e.g. agency expressed through the intentions of the body) and moreover that this is nourished by how others respond to that person and how they are treated; a person’s self is still present (although expressed differently) despite any apparent lack of capacity. Personhood implies recognition, respect and trust in others (Kitwood 1997, p.8). Based, it is contended, on Kitwood’s wider belief that there should be a moral concern for others (Dewing, 2008), personhood also is said to enable forms of moral praxis (Kitwood, 1990 p. 68).

According to Dewing (2008), attributes of personhood are discussed in three types of literature: theology and spiritual, ethics and social psychology with each assigning different significances. Among the attributes are included functions such as rationality, informed choice and decision-making combined with the ability to express emotion, consciousness and self-consciousness, morality and the capacity to form and hold social relationships (Dewing, 2008 pp. 6-7). Personhood is used to encapsulate the notion that the self predominates, however expressed or made known (it is not an attribute confined to the mind) and through action and relationships. This differs from the separation of mind and body and mind and brain proposed by others, a dualism which dominates the moral philosophy literature around personhood with the mind either somewhere else or no longer existing (Dewing, 2008 p.7). Personhood is also said to have primary and secondary criteria, the former in which a person is self-conscious and rational or ‘mind-full’ and the latter wherein these attributes are bestowed on ‘mind-less’ persons who are then deemed reduced and subject to others (Engelhardt, 1986 p. 109). Secondary criteria are of particular interest to those exploring personhood in dementia and is also present in this study but, first, personhood and its enactment is discussed.

In this study there is robust evidence that participants in how they view the person who is being assessed enact personhood and in so doing use it as compass without which approved mental health practice praxis is not possible. Present throughout the data and as shown in the analysis section ‘praxis,’ is the belief that the person is central; examples include participants talking of “remembering the person” and “putting the person in the middle”. This principle manifests itself in positive feelings towards the person being assessed including respect, empathy and being protective. This manifestation happens even when there is lack of mental capacity from the person subject to the assessment and sometimes in the face of opposition from others. This is



shown most blatantly through the actions of one social work participant in this same analysis theme when she talks of others in the assessment process not seeing the person and contends that he is such by pointing out that, like her, he is a parent. She does so despite the overt disgust which others are displaying towards him based she believes on their knowledge of that person's past 'bad' actions. Not only then is the overall purpose of approved mental health practice in this instance a moral concern for others, but moral actions occur when this participant constantly engages in good action even in the face of conflicting pressures, difficulties and dilemmas from others. This moral concern and action accords with personhood according to Kitwood (1997) and is moral praxis or eupraxia after Aristotle. However, when considering primary and secondary personhood, the analysis shows divergence. Participants, as is shown in the analysis theme 'praxis' defend the person and do so in spite of others. When they do so they are not however perceiving of the person as 'mind-less', albeit some are incapacitated, even when others are doing so, sometimes in an extreme way. Approved mental health practice is a value driven activity and to enact it participants must also see the embodied self as primary.

When embodied in practice, such praxis, in addition to defending the individual, also is used to defend approved mental health practice, and its significance. This is a further example of praxis but here where the principle being enacted in practice refers to approved mental health practice as a whole. Such praxis is not confined to a specific participant or professional group but is also present in the interpretation of the data of all participants. These participants, regardless of professional background also, in reflecting upon their practice, enact the personhood or, as referred to in the presentation of the findings, they apply the use of person. This use is shown through respect, being protective of individuals and, in turn, defending approved mental health practice and its

significance and is a more robust nature than non-conditional positive regard. The orientation of personhood therefore is fundamental to approved mental health practice, not just to the process, and is a significant new finding in this study.

### ***Influencing professional identity***

Also evident in this study is a further moral dimension in how participants talk about identity. The praxis of approved mental health practice is shown to influence the identity of the professional and specifically, as shown when, in their own words, nurses move from “unclean” to “honorary social workers”. The praxis of approved mental health practice influences the identity of the professional and specifically applies to nurse participants in this study. This is a significant finding in relation to the original aim of this study since it moves beyond the question as to what impact professional background has on practice but in effect does this in reverse; what impact does approved mental health practice have on professional background. To summarise the relevant section of the analysis ‘from unclean to honorary social workers’, when considered in the context of generic mental health roles nurse participants are at first certain that there is little difference between social workers, occupational therapists and themselves. However, when considered in the context of approved mental health practice, there is a change in how nurses perceive their professional identity whereby they move from typical to atypical driven by attributes which, whilst present in nursing are not, according to them, foregrounded. The praxis of approved mental health practice therefore influences the identity of the professional.

In this study, this praxis is most prominent from the standpoint of nurse participants and the transition they report from “unclean” to “honorary social workers”. To begin, nurse participants believe that the one difference between themselves and allied mental health

professionals is the ability to administer medication. However, when considered in the context of approved mental health practice this perception changes, albeit unconsciously. Evident in the use of a changing hats metaphor, a nurse participant at first is assured that the assessments she undertakes for approved mental health practice are no different from what she does as a nurse, but this for her changes later when she uses it to infer that she is doing something different. The hat analogy is present in other research into approved mental health practice which reported discontinuities between the day to day social work role and the approved mental health practice role, the latter necessitating the taking on of a different persona, or hat (Myers in Ulas and Connor, 1999). In this study, approved mental health practice for nurses, as for other participants, involves value driven considerations such as human rights and least restriction but these are attributes nurse participants had not hitherto placed at the forefront of their understanding of what is expected in nursing.

### ***The active use of dissonance***

When talking about what they do in the final two themes in the analysis participants find meaning which also builds on the resorting of traditional boundaries discussed earlier. In the analysis theme ‘the active use of dissonance or, “pull”’ behaviour is shown that challenges current understanding of the management and use of emotions in the workplace. This theme underpins the enactment of approved mental health practice. Meanwhile, as encapsulated in the idiom “popping someone’s bubble,” approved mental health practitioners deal with reaction, their own and that of others’. Both interpretations underpin the identity of approved mental health practice and are the basis of the last part of this discussion.

As primarily reported in empirical research, approved mental health practitioners are said to experience a range of emotions but primarily negative ones. Instead, the data in this research show a different understanding; first, that contradictory and sometimes conflicting emotions are experienced, both positive and negative and second, that approved mental health practitioners are aware of and simultaneously use these contradictory emotions to control the process of approved mental health practice. They harness the contradictions for gain. In addition, participants are shown to hover over the process being at the same time in control and yet not in control. Explained through the lens of emotion work and in particular the feeling rule, this study finds emotions new to what is the equivalent of the current approved mental health practice feeling rule but also a new aspect of it. This new aspect, or what is being termed ‘the feeling rule dichotomy’, is the approved mental health practitioner’s capacity explicitly to use cognitive and affective feeling, however contradictory, to accomplish practice. This use of the feeling rule is fundamental to approved mental health practice and has been a constant theme throughout this discussion.

Emotion work, sometimes termed emotional labour, is a sociological concept denoting the outward display of a feeling or emotion by an individual and the internal effort required by them for this display (Hochschild 1983). Underlying this concept is the belief that individuals present to others a feeling or emotion suitable for the particular social situation in which they are in such as, for example, displaying happiness which might be the expectation at a wedding and displaying sadness as might be the expectation at a funeral (Hochschild 1983). The common understanding by the individual and others about what emotion is expected in a given social situation is said to be understood implicitly and is referred to as a feeling rule. The most cited example of emotion work as applied in the workplace is that based on a study of airline hostesses

(Hochschild 1983) from which it is argued that in the workplace individuals form or subjugate feeling according to what, in effect, is the understood feeling rule of the workplace.

For Hochschild, the airline hostess forms and displays emotions such as being calm but subjugates others, such as anger. The individual worker displays the required emotion and subjugate others, not according to any implicitly understood social feeling rule, but because the explicit workplace feeling rule requires them to do this in order to achieve the product, in this instance satisfaction for the airline customer. This product, satisfaction, is for Hochschild emotional labour and is the equivalent of other workplace products such as those achieved through physical labour. However, and in contrast with emotion work in the social situation, Hochschild contends that emotional labour also involves a loss of control for the individual over the effort they expend in displaying emotion and of their choice in doing so. This loss of control is either superficial or in-depth and coined by Hochschild as surface or deep acting; the former involves a careful presentation of feeling, the latter involves the individual actually experiencing the required emotion.

The original concepts of emotion work and emotional labour have been used extensively to examine emotion in the workplace and questioned. One such critique (Bolton and Boyd, 2003) offers an alternative typology, elements of which are prescriptive, presentation, pecuniary and philanthropic. Display of emotion by the individual takes place also as a result of the understanding of this workplace feeling rule and the product, again in this instance customer satisfaction, arises. But, the authors of the typology challenge Hochschild's assertion that the individual, during the process of creating the product, loses choice or control over the display of emotion. Rather, it is

suggested that individuals are capable of mixing and managing all forms of emotions in the workplace.

Thus far the feeling rule is applied to commercial organisations and determined by them. Other organisations such as those that provide formal care can also be viewed in terms of the feeling rule. Examples of such organisations in England include Local Authorities and National Health Service Trusts where individuals are employed to provide care as a service or product. These organisations are known as public services and include social workers, nurses and occupational therapists. In some formal care workplaces, the product also involves a duty as laid down in a legal statute. This is true of the workplace equivalent approved mental health practice, where the individual is required, through what is in effect a workplace feeling rule, to assess and sometimes make application for admission to hospital. This decision is the core function of approved mental health practice, and is the process which leads to the product; product in this case means a mental health act assessment. In the analysis (Chapter Four pages 157 -167) it is shown that participants manage all forms of emotions in the workplace but in particular they use contrasting emotions or in their words “pull” in order to control the process, or generate the product. This is another aspect of the feeling rule, and what is being termed here ‘the feeling rule dichotomy’.

A review of the empirical research about approved mental health practice reveals no acknowledgement of an equivalent of the workplace feeling work. Instead, what is found is that approved mental health practice is typified by the experience and impact of negative emotions (Evans et al., 2005, Evans et al., 2006, Huxley et al., 2005 and Hudson and Webber, 2012). Text books and other manuals written to guide approved mental health practitioners focus on knowledge and application of the law and of understanding practical matters (Adshead et al., 2009, Barber et al., 2011, Barcham

2012, Brown, 2013, Olsen, 1984, Sheppard, 1990). Just one seeks to explore approved mental health practice as it is experienced emotionally and its editors argue that approved mental health practice is about working with uncertain situations where there are no rules including, it is implied, no rule that might constitute a workplace feeling rule or equivalent (Matthews et al., 2014).

What does exist as an equivalent of a feeling rule for approved mental health practice is found in guidance for the approval and training of approved mental health practitioners. The statutory regulations which outline the factors to be taken into account when deeming a person's competence to undertake approved mental health practice in England and Wales include: the ability to manage difficult situations of anxiety, risk and conflict, reflecting on how this affects themselves and others (Her Majesty's Government, 2008 paragraph 4.6). This requirement is also repeated by the body which regulates the education and training programmes of Approved Mental Health Professionals, also in England and Wales: all such programmes must assess the individual's ability to be able to manage anxiety, risk and conflict and understand its impact on Approved Mental Health Professional practice (Health and Care Professions Council 2013 p. 11). Dealing with anxiety and the emotions incurred when dealing with risk and conflict along with being able to reflect on the impact of these emotions on oneself as a worker and on others is then the current equivalent of a feeling rule for approved mental health practice. Data analysis as shown in the theme '“pull”: the active use of dissonance', finds in the first instance that approved mental health practitioners experience emotions such as those laid down in these existing regulations or, the equivalent of the approved mental health practice workplace feeling rule.

However, interpretation reveals that approved mental health practitioners also experience different and sometimes contrasting emotions including, for example,

satisfaction and pride whilst simultaneously experiencing anxiety and concern. Since these emotions do not to date feature in what is the equivalent of the current feeling rule for approved mental health practice they therefore begin, through the analysis of the data, to challenge understanding of it. Further interpretation of the data shows that participants also recognise on occasion not being in control of the work while, *crucially*, simultaneously using a contradictory emotion to gain this control, and thereby generate the outcome. Emotions experienced simultaneously that may appear dichotomous are not experienced as such. Emotional labour is said by Hochschild to involve a display of emotion over which the individual loses control in order to create the product (Hochschild, 1983). However, this study finds awareness and use of contrasting feeling to control the process. This is then not emotional labour as Hochschild defines. Instead, Bolton and Boyd's (2003) mixture and management of a range of emotions is applied here but is also extended; approved mental health practice involves use of contradictory emotions in order to control the process and achieve the outcome. It is also shown that participants regardless of professional background have the experience of emotions *co-existing* in their reflections on practice; 'the feeling rule dichotomy'.

The use of the feeling rule dichotomy in approved mental health practice is best understood through the idiographic interpretation of what one social worker participant means when they describe simultaneously being pulled emotionally in every direction but also, and significantly, not being pulled. This practitioner actively uses the dissonance between what they are feeling in the here and now and what might be considered more appropriate feeling rules in that context and in the context of performing a role. The dichotomous feeling rule acts as a spur to specific effective professional actions. Such "pull" is also apparent in the interpretation of the accounts of other participants, for example when one participant depicts approved mental health



practice as “popping someone’s bubble” (Chapter Four pages 180-194). The participant is using this idiom to encapsulate the control and simultaneous lack of control he has over the process. The feeling rule dichotomy is further explained when another interpretation of participants’ meaning shows that approved mental health practitioners, in effect, use feeling to ‘hover’ over the situation and to slow it down. According to one commentator (Banks, 2013, Banks, 2016), role work involves judging what role to take with *particular people in particular circumstances* including how and when to shift between roles with a degree of professional closeness or greatness. In this study participants are seen to hover over situations to control but also at the same time to allow chaos. They are not moving, as Banks (2016) might suggest, between the two but are simultaneously using two dimensions. The meaning of hovering for approved mental health practitioners is that they explicitly use contradictory emotions as a way of controlling practice even though on occasion this may mean allowing, albeit temporary, loss of control. This then is a different understanding of the original feeling rule; the recognition of seemingly not being in control of the process while, *crucially*, simultaneously using contradictory emotions to generate this control and thereby the outcome. Participants also reflect upon these emotions and their impact. The range of emotions are experienced by social workers, nurses and occupational therapists alike and, as such, all are features of approved mental health practice. This, the feeling rule dichotomy, is a fundamental aspect of the experience of undertaking approved mental health practice for the participants in this study and an important finding.

One possible reason for this occurrence is that the outcome and the process are governed not just by the feeling rule, albeit extended here to include new emotions and involve the dichotomy, but by a legal duty. Put simply perhaps, approved mental health practitioners use the feeling rule dichotomy in order, in Hochschild’s terms, to achieve

the product; undoubtedly the legal duty, an assessment and sometimes an application for compulsory detention, is undertaken. At first glance approved mental health practitioners do not have any choice over this product. As one participant clearly states the product has to happen, this is a legal duty and practitioners “can’t get away”. The ‘customer,’ that is the person subject to this assessment and possible application does not agree, accept or want this product. Moreover, in approved mental health practice the process does not always have to end in an application since part of the role could be to decide not to make an application. For approved mental health practice the product is a function of the legal duty but its creation is under the control of the individual approved mental health practitioner. There is also significant use of feeling to control the process which in turn achieves the product.

### **Conclusion to the chapter**

This study set out to understand the impact, if any, professional background has on a legally determined role; in this case currently practising Approved Mental Health Professionals. The study has also explored the emotional aspects of this work as experienced by participants.

Discussed in light of what is termed *the role in practice*, it is shown that professional background does not influence practice but rather in fulfilling the role one’s professional identity becomes influenced. Approved mental health practice has common *instrumental* functions and also shared values, actions and learning that are held in common. Other affective and cognitive attributes emerge. When undertaking approved mental health practice practitioners must simultaneously be able to manage ‘the determined and the undetermined,’ regardless of professional background. This balance

of seemingly disparate elements is a thread which runs throughout the findings and a different appreciation of the accomplishment of approved mental health practice.

The social perspective, often conflated with social alternatives, is rarely enacted in practice. This is an observation in this study which also supports the hypothesis that to align it with the social worker profession originally, and now all professions who undertake approved mental health practice, is an inherent contradiction. This received moral framework is a stance in name only but this perspective persists. It is defended, especially and interestingly so in terms of the overall aim of this research, by the profession of mental health nurses. This observation begins to move this research beyond its original aim.

Approved mental health practice is viewed as a morally justifiable role and is defended as such by participants in this study. However, to extend Hughes' dirty work metaphor, resorting of role boundaries is shown in the characteristics and behaviours of nurses as approved mental health practitioners. This behaviour is a change to the expected nurse-doctor deference and also indicates a variation to normative approved mental health practice and a new finding. Instrumental aspects of approved mental health practice are underpinned by an additional moral imperative, a discussion which brings to a close the first part of the chapter.

In the second part, there is the core finding that approved mental health practice incorporates theoretical stances other than the social perspective and these are in contrast, and *crucially*, enacted. Although as the original research aim indicates, this study is focussed on approved mental health practice, key findings have been the orientation of those participants involved to elements of what is being termed *the role in praxis*. From these perspectives other new insights have emerged.

Two aspects of praxis are discussed. First, participants are shown, on reflection, to realise theory as used in practice. Personhood, after its originator (Kitwood, 1997), is a fundamental but, as yet, unrecognised element of approved mental health practice in praxis and as such is also being practiced in a different context than previously considered. Second, the praxis of approved mental health practice is shown to influence the identity of the professional which is of particular note given the original aim of this study since it relates to those participants who are mental health nurses. This particular finding also suggests that approved mental health practice has influence on professional identity rather than the reverse, as was originally hypothesised. Both aspects of praxis are core to this thesis.

Last, approved mental health practice is shown to involve an *active use of dissonance* providing new insights into the enactment of the role and use of emotion in the workplace. Approved mental health practice is shown to involve sophisticated emotion management by individual participants irrespective of professional background and provides a new understanding of it, ‘the active use of dissonance’ as it is being termed.

## **CHAPTER SIX**

### **Conclusion to the thesis**

#### **Introduction to the chapter**

This final chapter concludes with the implications of this thesis for future practice and research, followed by a discussion of its limitations and, simultaneously, of its strengths. Reflection and reflexivity as carried out by the author is also included using excerpts from the reflective journal maintained during the process of analysis which illustrate this process in real time. Last, the very technique that the author asked of her participants, the drawing of a Rich Picture, is used. This picture seeks to encapsulate the author's experience of the research journey, through reflection. A commentary is provided in the first person as to the researcher's role including what has been learned, thoughts as to the advantages and disadvantages of using IPA, the effects the researcher had on the process and what was done about this. The Rich Picture is included here in whole and is described also in the first person to bring this thesis to a close.

#### **Implication for practice and research**

Approved mental health practice as accomplished in this study is not synonymous with one profession. The attributes required to achieve it are present in these examples of approved mental health practice, regardless of background. Approved mental health practice is an important statutory function and is undertaken instrumentally but what also happens during its execution is a cognitive and affective appraisal of the processes involved, requiring its practitioners to simultaneously manage being determined and undetermined, a theme which threads throughout this thesis. This attribute is a significant issue for future practice; approved mental health practitioners are active moral agents but not just as an antidote to the legal or medical. Instead, they embrace

and are able to hold and use disparate elements that are present in order to undertake and defend the significance of the role. This is a central aspect of approved mental health practice and of its practitioners; the capacity, irrespective of professional background, to simultaneously balance both cognitively and affectively all aspects of the processes which arise, including how it is experienced. This finding indicates that approved mental health practice is most effectively undertaken by practitioners who have particular attributes and not those from a particular professional background as such.

As discussed in Chapter One, the social perspective is the received moral framework for approved mental health practice but this study, in line with others, suggests it is accomplished in name only. Arguably, the contemporary context in which Approved Mental Health Professionals practice differs given the mass closure of hospital beds and in some geographical areas home treatment and crisis teams are tried before an assessment. For some practitioners this context might influence the current experience of undertaking the role where, as discussed in Chapter Five. This contradiction provides a first indication in this study of the relationship between *the role in practice* and *the role in praxis* confirming that there is little connection between the currently accepted normative moral framework and practice. An implication of this renewed discovery is, that unless viable social alternatives are available, the moral framework of approved mental health practice needs reconsideration and that practitioners and policy makers accede that this aspect remains aspirational.

This conclusion might also provide some explanation as to why the demographic make-up of people detained in hospital mirrors the attributes of a socially disadvantaged population, a question that remains unanswered at present. Given this, the fundamental worth of approved mental health practice is brought into question since it is arguably an

inherent weakness in its core purpose. In addition, and ironically, approved mental health practitioners are shown to undertake ‘non-approved’ work. Both outcomes suggest that the role may not function independently of systemic norms. It also raises the possibility that opening up approved mental health practice to other non-medical mental health professionals might change traditional role boundaries.

This possible change is especially true for nurses in this study who, through approved mental health practice, begin to alter the nurse-doctor relationship. In doing approved mental health practice nurses believe they are being accepted as “honorary social workers” but this is, in essence, a metaphor for taking on the instrumental and moral attributes required to accomplish it and not just synonymous with social work, which is a distraction. Approved mental health practice, as it is currently accepted, is being challenged to some extent by the way nurses in this study are shown to accomplish it. In line with the policy outlined in Chapter One, this could signify both a new way of working for nurses and a new way of working for approved mental health practitioners. However, further research on this topic needs to be undertaken before the impact on professional role boundaries is more clearly understood. A natural progression of this current study is to explore other mental health roles that are subject to new ways of working, in particular that of the Approved Clinician.

Additional aspects of the moral framework for approved mental health practice have emerged and are first understood in this thesis by the incorporation simultaneously of moral contradictions, encapsulated in this study through the constructs of dirty and clean. The capacity of approved mental health practitioners to manage opposing elements is a consistent finding and provides some support for the conceptual premise that it is a psychiatric occupation in which there are ambiguities in the combination of duties. This finding makes a substantial contribution to the current literature and is

potentially an antidote to the flaw in its purpose as was earlier suggested since it focusses on the strength that is approved mental health practice.

This capacity, and additional aspects of the moral framework for approved mental health practice, is best understood as reflective enactments of theory, specifically as found in this thesis, personhood. Such praxis is a core finding and a deep-seated aspect of approved mental health practice and its application and is also being considered in a different context. The present study appears to be the first to associate conceptualisations of the person with approved mental health practice. For current practitioners and those who train and manage them, the understanding and application of personhood needs to be incorporated into the teaching and development of the role. For policy makers, personhood needs to be aligned with both the significance and justification of approved mental health practice in the provided guidance and other matter.

Just as there is evidence that through personhood, approved mental health practitioners are putting theory into practice, it is also shown that the praxis of the role influences the identity of the professional. Turning on its head the original hypothesis in this study which surmised that professional background might impact on approved mental health practice, this conclusion instead may help others to better understand the impact that new ways of working in mental health might have on traditional professional roles. As summarised in the context to this study the assumption that any mental health profession can carry out tasks regardless of professional background is a well-established policy driver, but the implications of it are not yet fully understood. The contribution of this study has been to confirm that professional background matters only in some respects, that of attribute and emotional management.



Although this study found that approved mental health practice is not bound by professional background it does conclude that its practitioners require particular attributes, specifically a cognitive and affective capacity to deal with and use discord. Participants manage disparate emotions to enable approved mental health practice and it is this feature which is most salient. Emotion management is a key feature, particularly the active use of dissonance. Conceptualised in this thesis as “pull,” this process constitutes a different understanding of the use of emotion in the workplace and significantly adds to the current understanding of the sociological concept of the feeling rule. Mental health legislation and the accompanying Codes of Practice, which in effect translate the law into working practice, could prescribe the approved mental health practice feeling rule. As seen in this study, participants speak of the security experienced because of the legal framework but Guidance does not as yet contain any reference to such workplace rule, or equivalent. Apart from the social perspective, currently prescribed expectations are technical or instrumental matters only. It is therefore suggested that in future iterations of such Guidance the inclusion of the feeling rule dichotomy, as it is termed, is incorporated through definition of it and a criterion that tests it. In turn, attention should also be paid to its fulfilment both in the selection, training and ongoing development of approved mental health practitioners.

### **Strengths and limitations**

This thesis has simultaneous strengths and limitations. First, the number of participants is small. This particular limitation might for some suggest that the findings have to be interpreted cautiously. However, the underpinning methodology provides a robust rationale for such numbers and also a justification for what are idiographic understandings. The study was not specifically designed to evaluate quantity or be representative but to establish defensible propositions that may have a wider

significance in different contexts and be validated or challenged in the future in varied circumstances.

It is acknowledged that the participants are unique. Nurses and occupational therapists may be distinct among their professional peers for taking on the role of the Approved Mental Health professional and are a small proportion of the workforce as a whole. A limitation may therefore be that the findings are based on atypical workers.

With regard to the research methods, the study used a purposive, homogenous sample. Participants, therefore, brought a perspective peculiar to them and the findings may have been different with a different sample. Again, the methodological approach is crucial in this respect. The analysis of data has been undertaken in depth and findings have arisen by making sense of participants making sense. It is, then, an interpretative, experiential exercise from which broader conclusions are not the primary objective. A strength of the present study is that it has idiographic depth as discussed in Chapter Three. Quantitative designs, such as an examination of the outcomes of Mental Health Act assessments to see if they differ according to professional background would potentially enable an evaluative examination as to whether the role is being performed differently. It is unfortunate that the make-up of participants included just two occupational therapists. Their presence in the data and the interpretation of it is therefore less when compared with the presence of other professional backgrounds. At the time of accessing participants, just eight occupational therapist approved mental health practitioners had been approved in England. Of these eight at least one to the author's knowledge is no longer practising. A possible area for future research would be to investigate why the uptake is seemingly so low and to explore whether this is a result of systemic barriers or that the attributes required do not sit readily with this particular

profession. In addition, the views of psychologists, doctors nor those assessed under the Mental Health Act were sought and may have provided a different perspective.

A final factor, that is simultaneously a limitation and a strength of this thesis, is that of the author and her professional identity, a qualified and registered social worker who has extensive lived experience as an approved mental health practitioner, albeit not current. This experience has meant that whilst being able to readily empathise with participants, there has also been a particular needed to put this previous understanding to one side in order to question or, in other words, enact both the double hermeneutic and the phenomenological reduction. To achieve both been a significant test.

One way to address this potential limitation but also a strength has been the completion of a reflective journal during the analysis and write up of the data. This journal recalls in real-time the author's thoughts about the process and her influence on it. It also, and crucially, has been a way of allowing the need to bracket, where possible, previous understanding, a process which is of central importance to quality and validity.

Reflection and reflexivity are both measures of quality and validity in all qualitative research and this is no different in studies that use IPA (Smith et al., 2009 p. 182). What follows is a discussion of reflection and reflexivity as this has been achieved in this thesis. Excerpts of the author's journal and the researcher's own Rich Picture of the research process and reflection thereon are used to illustrate.

### **Reflection and reflexivity**

The following excerpts provides an example of the internal mental struggle that was had by the author in selecting a theme. The dilemma concerned whether a theme should be based on quantity of code entry or of finding a 'pearl' (Smith, 2011c), neither, or both:

*This issue was prompted as I started to try and write up the analysis of themes from the data. I was simultaneously intrigued by the critique of this by Blumer (1956) as reported by Stanley and Temple (1995). The question Blumer addresses is: what criteria are used to select-in some and select-out others. I am trying to relate this question to the process I have been undertaking in order to 'arrive at' a first theme. For example, I thought it might be a good place to start with the code(s) which contained the most references and at least one from each of the participants as follows in my first draft of a theme which I have to date entitled reconciling negative and positive emotions.*

Excerpt from the reflective journal (the author)

The author also understood that that the best quality research using IPA urges the analyst to go beyond first level description (Larkin et al., 2006). Moving through empathy to questioning, the author was able to show one understanding of the double hermeneutic in IPA and also to distance herself from the description and to interpret:

*This, as it transpires, was however a first level descriptive analysis. Upon second level analysis as required of Interpretative Analysis, it became clear that the meaning for the participant as interpreted by me had two aspects. Engaging in the double hermeneutic gave rise to an alternative meaning of dealing with difficulty since, simultaneously, and as recorded in separate codes the participants described positive emotions and experienced feelings of coping and resilience. Through the coding I had captured and in turn commented on these codes in the memos I had linked to them. In so doing, it became clear to me that there was a theme emerging concerning the reconciliation of what are seemingly irreconcilable emotions.* Excerpt from the reflective journal (the author)

According to IPA, adopting the phenomenological attitude is imperative, but the author remained unsure of the transparency of this and decided at this point to refresh their knowledge of the review of the empirical studies. Dealing with difficult emotions is a theme which occurs in these studies and they referred to this in their reflective journal as a means of putting this knowledge to one side whilst continuing to analyse:

*As discussed in the review of the literature of empirical evidence, several studies have reported on undertaking mental health social work and also assessments under the Mental Health Act in the context of the difficult emotions. Factors concerning stress in work situations present themselves in a negative way such as the personal emotional impact on the individual including burnout; a shorthand reference for psychological constructs such as emotional exhaustion (depletion of emotional resources leading workers to feel unable to give of themselves at a psychological level); depersonalisation (negative, cynical attitudes and feelings about clients) and reduced personal accomplishment (evaluating oneself negatively, particularly with regard to work with clients.. This review however also highlighted that whilst the work can include these negative aspects of stress, and this is not to be ignored, approved mental health practice is also experienced as exhilarating or ‘ a double edge sword’(ref)*

Excerpt from the reflective journal (the author)

At this point in the analysis the author reflected that further work on the process of analysis was needed. For Stanley and Temple (1995) their concern is whether data are being analysed to make explicit or discover ideas which are seen as somehow a priori embedded within the data, or whether the data are being analysed to explore theoretical

ideas derived from outside of the data. This was for the author in this study the first struggle in undertaking the analysis and an illustration of the required reflection and reflexivity.

This chapter also affords an opportunity to reflect upon the research journey and what has been learned. As will be seen in the researcher's own Rich Picture and description of it, the ride has not always been a smooth one. What follows is a commentary in the first person discussing lessons learned, reflecting on the use of IPA and on what she may have done differently. This is presented in italics:

*I have learned that undertaking a research study is an emotional experience from which it is hard to detach oneself. This may have been a particular consequence of the methodological approach used since it required in-depth immersion but, I suspect this emotional investment applies to all research. I am happy that the particular methodology used in this study was the most appropriate given its original aim and objectives. The particular subject has been a long held professional interest and the accomplishment of the research a personal challenge. I have at times felt deskilled. My 'day job' is a Senior Lecturer in a University. It has been especially challenging to return to being a student and to get back to the basics of study and develop new skills. To do so over such a long period of time whilst also undertaking my parallel professional existence has also been a test.*

*That said, there is not much I would change. Apart from a long held interest in the topic, I have been especially keen to understand and learn the pure research process. This study has enabled me to identify a research question, the aim and objectives and learn to hold onto this through the various stages involved. The examination of various methodologies and ultimate use of IPA has been especially enjoyable for me since it*

*afforded a new insight into the philosophical debates about knowledge. The advantages of using IPA in this thesis have been various. It has enabled an in-depth exploration of role fulfilment and the experience thereof. It has also afforded me as a sole researcher to be immersed in participants' meaning and in turn to make meaning of this.*

*Conversely, the analysis requires lengthy involvement. Undertaking the research over a long period of time was a personal necessity but this is also a strength since in-depth analysis affords justice to the methodology. Putting to one side any previous knowledge or understanding has been a necessary challenge.*

*The literature search and review I found less enjoyable. It is of course crucial to orientate research into the context of what has gone before and to identify the reason for and gap which the present study seeks to fill. I enjoyed searching and reviewing the evidence but took some time to alight upon the type of review and a tool that enabled me to include different types of knowledge. That is not to say that a literature search and reviews should not be transparent and defended, but rather to acknowledge that evidence is possible through various means. I was also on occasion taken aback by the poor quality of some published research. The learning has undoubtedly allowed me to develop further skills in critical analysis.*

*Allowing participants to find meaning through their interviews and their drawing and explanation of a Rich Picture has also meant an adaptation of otherwise practiced interview skills. I have learned that the function of an interview as I would conduct it in my previous professional world differs from that of the function of an interview for research purposes. For me, the use of Rich Pictures brought an important new dimension to this interview process and had two functions: it meant that participants did not always use the restricted language that can sometimes arise through familiarity. It also for the participants became a reflective tool in itself.*

*Writing up has concluded this emotional ride. Having the confidence to express what I have found in the data has taken time and, I am not wholly convinced that I have achieved this in full. The review and amendment of chapters, sometimes quite wholesale, has simultaneously been painful and exhilarating. Presenting data and discussing findings is a creative process deserving of time and energy. My voice is beginning to appear in my work, and I know that this confidence will grow as I take the next stage which is to make the findings public.*

The final part of this chapter shows the Rich Picture drawn by the author towards the end of her thesis experience and a description of it. Together, these bring this thesis to a close:

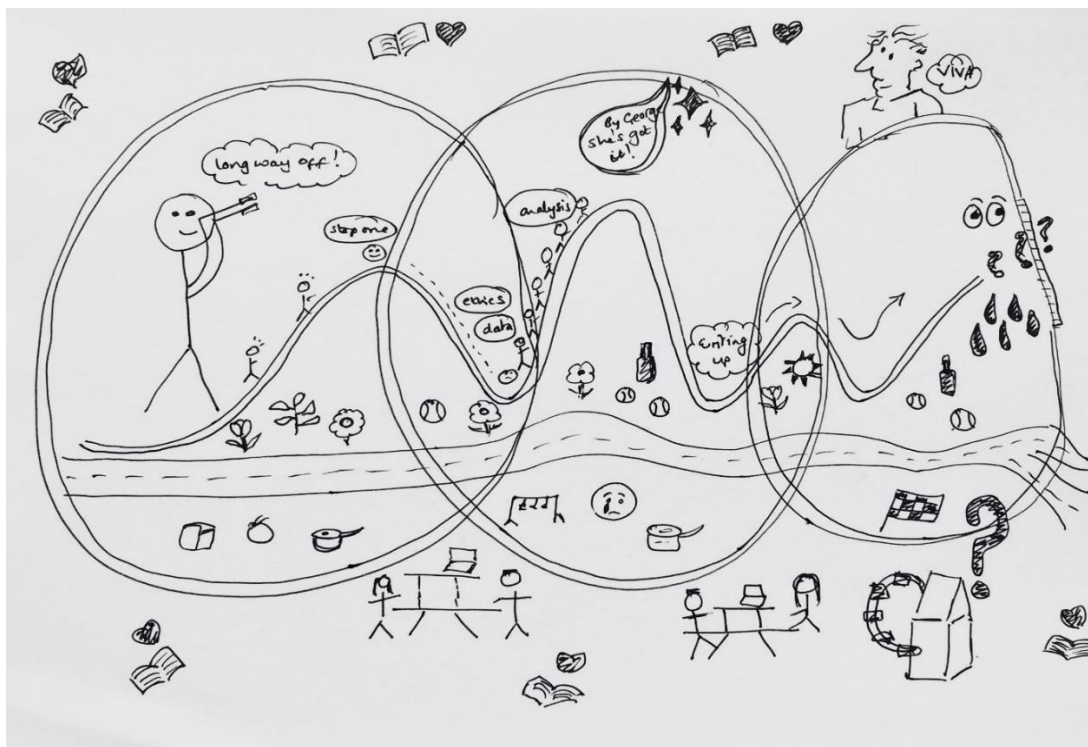


Figure 6.1. Rich Picture: the thesis experience.

My Rich Picture depicts the roller coaster I have been on throughout my lived thesis experience, a common metaphor I have no doubt. It has taken place in three distinct phases, punctuated with steep learning curves, the moments of exhilaration that comes



with understanding and also those of frustration and despair. I wondered at times if the process would ever end; when one element completed another seemed to begin. The submission and viva, the last phase, still await of course! Running underneath all of this has been my life: looking after my family, my love of gardening, a traumatic personal loss, my 'day' job and, above all, the parallel academic journey of my youngest child who sat beside me in the kitchen as we both studied. She is now moved on joining the rest of my children in their adult lives and I am at a crossroads. I await the finish tape on this particular experience and am also now wondering what my academic and work future might bring, tinged both with sadness and excitement. My love of reading and learning persists.

## REFERENCES

- Adshead, G., Pollard, A. and Brown, R. (2009). *The Approved Mental Health Professionals guide to psychiatry and medication*. Exeter: Learning Matters.
- Arendt, H. (1958). *The human condition*. Chicago: University of Chicago Press.
- Banks, S. (2013). Negotiating personal engagement and professional accountability: Professional wisdom and ethics work, *European Journal of Social Work*, Vol. 16(5), pp 587-604.
- Banks, S. (2016). Everyday ethics in professional life: Social work as ethics work, *Ethics and Social Welfare*, Vol. 10(1), pp 35 -52.
- Barber, P., Brown, R. and Martin, D. (2011). *Mental health Law in England and Wales: A guide for mental health professionals*. London: Sage.
- Barcham, C. (2012). *The pocket book guide to mental health assessments*. Maidenhead: Open University Press.
- Bazeley, P. and Jackson, K. (2013). *Qualitative data analysis with NVivo*, 2<sup>nd</sup> edn. London: Sage.
- Bean, P. (1980). *Compulsory admissions to mental hospitals*. Chichester: John Wiley and sons.
- Bolton, S. and Boyd, C. (2003). Trolley Dolly or Skilled Emotion Manager? Moving on from Hochschild's Managed Heart, *Work, Employment and Society*, Vol. 17(2), pp. 289-308.
- Bowers, L. Clarke, N. and Callaghan, P. (2003). Multidisciplinary reflections on assessment for compulsory admission: The views of Approved Social Workers, General Practitioners, Ambulance Crews, Police, Community Psychiatric Nurses and Psychiatrists, *British Journal of Social Work*, Vol. 33 pp. 961-968.
- Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology, *Qualitative Research in Psychology*, Vol 3(2) pp. 77-101.
- Bressington, D.T., Wells, H. and Graham, M. (2011). A concept mapping exploration of social workers' and mental health nurses' understanding of the role of the Approved mental Health Professional, *Nurse Education Today*, Vol 31, pp. 564-570.
- British Association of Social Workers (2005). Evidence to Joint Committee on the Draft Mental Health Bill, Session 2004-2005, Vol II, EV 577.
- Brocki, J.M. and Wearden, A.J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology, *Psychology and Health*, Vol 21 (1), pp. 87-108.

- Brown, P. (1989). Psychiatric dirty work revisited, *Journal of Contemporary ethnography*, Vol. 18(2) pp 182-201.
- Brown, R. (2002). The changing role of the Approved Social Worker. *Journal of Mental Health Law*, Vol. 1, pp. 392-398.
- Brown, R. (2013). *The Approved Mental Health Professional's guide to mental health law 2<sup>nd</sup> edn*, Exeter: Learning Matters.
- Campbell, J. (2010). Deciding to detain: The use of compulsory mental health law by UK social workers, *British Journal of Social Work*, Vol. 40, pp. 328-334.
- Campbell, J. Wilson, G., Britton, F., Hamilton, B. Hughes, P. and Manktelow, R. (2001). The management and supervision of Approved Social Workers: Aspects of law, policy and practice, *Journal of Social Welfare and Family Law*, Vol 23(2), pp. 155-172.
- Carr-Hill, R. (1998). Evidenced based health care: Flaws in the paradigm? *Journal of the Royal Society of Medicine*, Volume 91, Supplement 35, pp. 12-14.
- Chamberlain, K. (2011). Troubling methodology, *Health Psychology Review*, Vol 5, pp. 48-54
- Charmaz, C. (2008). *Constructing Grounded Theory (Introducing Qualitative Methods Series) 2<sup>nd</sup> edn*, London: Sage.
- Checkland, P. (1980). *Systems thinking, systems practice*, London: Wiley.
- Christian, L. (1985). *Approved Social Work? Ten mental health case studies - before and after the '83 Act*, Social Work Monographs, University of East Anglia.
- Davidson, G. and Campbell, J. (2010). An audit of assessment and reporting by Approved Social Workers (ASWs), *British Journal of Social Work*, Vol .40, pp. 1609-1672.
- Department of Health (1998). *Modernising mental health services: safe, sound and supportive*, London: Department of Health.
- Department of Health (1990a). *National service framework for mental health. Modern standards and service models* Department of Health, London.
- Department of Health (1990b). *Effective care co-ordination in mental health services. Modernising the Care Programme Approach*, London: The Stationery Office.
- Department of Health (1999). *Review of the Mental Health Act 1983: Report of the expert committee*, London: Department of Health.
- Department of Health (2004). *Ten essential shared capabilities: A framework for the whole of the mental health workforce*, London: Department of Health.

Department of Health (2005a). *New ways of working for psychiatrists: Enhancing effective person-centred services through new ways of working in multi-disciplinary and multiagency contexts*, London: Department of Health.

Department of Health (2005b). *Reform of the Mental Health Act: Summary of consultation responses*, London: Department of Health.

Department of Health (2007). *New ways of working for everyone - a best practice implementation guide*, London: Department of Health.

Department of Health (2015). *Mental Health Act 1983: Code of Practice*, London: Department of Health.

Dewing, J. (2008). Personhood and dementia: revisiting Tom Kitwood's ideas, *International Journal of Older People Nursing*, Vol. 3, pp. 3-13.

Dixon-Woods, M., Bonas, S., Booth, A., Jones, R., Miller, T., Sutton, A., Shaw, R., Smith, J. and Young, B. (2006). How can systematic reviews incorporate qualitative research? A critical perspective, *Qualitative Research*, Vol. 6(1), pp. 27-44.

Douglas, M. (1966). *Purity and danger: an analysis of concepts of purity and taboo*, London: Routledge and Kegan Paul.

Elliott, R., Fischer, C.T. and Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields, *British Journal of Clinical Psychology*, Vol 38, pp. 215-229.

Emerson, R. and Pollner, M. (1976). Dirty work designations: their features and consequences in a psychiatric setting, *Social Problems*, Vol. 23(3), pp. 243-254.

Engelhardt, H. (1986). *The foundations of bioethics*, New York: Oxford University Press.

Evans, S., Huxley, P., Gately, C., Webber, M., Mears, A., Pajak, S., Medina, J., Kendall, T. and Katona, C. (2006). Mental health burnout and job satisfaction among mental health social workers in England and Wales, *The British Journal of Psychiatry*, Vol. 188, pp. 75-80.

Evans, S., Huxley, P., Webber, M., Katona, C., Gately, C., Mears, A., Medina, A., Pajak, S. and Kendall, T. (2005). The impact of 'statutory duties' on mental health social workers in the UK, *Health and Social Care in the Community*, Vol 13(2), pp. 145-154.

Fakhoury, W.K.H and Wright, D. (2004). A national survey of Approved Social Workers in the UK: Information, communication and training needs, *British Journal of Social Work*, Vol 34, pp. 663-675.

Finlay, L. (2006). "Rigour," "ethical integrity" or "artistry"? Reflexively reviewing criteria for evaluating qualitative research, *British Journal of Occupational Therapy*, Vol 69, pp. 319-326.

- Finlay, L. (2008). A dance between the reduction and the reflexivity: Explicating the phenomenological psychological attitude, *Journal of Phenomenological Psychology* Vol 39, pp. 1-32.
- Finlay, L. (2011). *Phenomenology for therapists: Researching the lived world*, Chichester: Wiley-Blackwell.
- Fisher, M. Newton, C. and Sainsbury, E. (1984). *Mental health social work observed*, London: George, Allen and Unwin.
- Friere, P. (1972). *Pedagogy of the oppressed*, Harmondsworth: Penguin.
- Garfinkel, H. (1967). *Studies in Ethnomethodology*, America: Prentice-Hall.
- Gee, P. (2011). 'Approach and sensibility': a personal reflection on analysis and writing using interpretative phenomenological analysis, *Qualitative Methods in Psychology Bulletin*, Vol 11, pp. 9-22.
- General Social Care Council (2012). GSCC targeted inspections of Approved Mental Health Professionals (AMHPs) courses in England, 2012-2011, London: General Social Care Council.
- Gil-Rodriguez, E and Hefferon, K. (2012). London IPA Training materials, accessed December 2012.
- Gilbert, P. (2003). *The value of everything: social work and its importance in the field of mental health*. Lyme Regis: Russel House publishing.
- Giorgi, A. (2010). Phenomenology and the practice of science, *Existential Analysis*, Vol 22, pp, 3-22.
- Giorgi, A. (2011). IPA and science: a response to Jonathan Smith, *Journal of Phenomenological Psychology*, Vol 42, pp. 195-216.
- Glaser, B.G. (1992). *Basics of Grounded Theory Analysis: Emergence versus forcing* Mill Valley, California: Sociology Press.
- Glaser, B.G. and Strauss, A.L. (1967). *The Discovery of Grounded Theory: Strategies for qualitative research*, Mill Valley, California: Sociology Press.
- Godden, J. (2013). National AMHP survey: Reaction from the social work frontline *Community Care*, October 2<sup>nd</sup>.
- Gostin, L. (1975). *A human condition Volume I. The Mental Health Act from 1959 to 1975: observations, analysis and proposals for reform*. London: MIND
- Gould, N. (2006). An inclusion approach to knowledge for mental health social work practice and policy, *British Journal of Social Work*, Vol 36, pp. 109-125.
- Gray, M. and Lovatt, T. (2007). Horse and Carriage: Why Habermas's discourse ethics gives virtue a praxis in social work, *Ethics and Social Welfare*, Vol 1(3), pp. 310-328.

- Gregor, C. (2010). Unconscious aspects of statutory mental health work: Emotional labour and the Approved Mental Health Professional, *Journal of Social Work Practice* Vol 24, pp. 429-423.
- Guillemin, M. (2004). Understanding illness: Using drawings as a research method, *Qualitative Health Research*, Vol 14, pp. 272-289.
- Guba, E.G. and Lincoln, Y.S. (1982). Epistemological and methodological bases of naturalistic inquiry, *Educational Communication and Technology*, Vol 30(4), pp. 233-252.
- Hatfield, B. (2008). Powers to detain under mental health legislation in England and the role of the Approved Social Worker: An analysis of patterns and trends under the 1983 Mental Health Act in six local authorities, *British Journal of Social Work*, Vol. 38, pp. 1553-1571.
- Hatfield, B. and Antcliff, V. (2001). Detention under the Mental Health Act: Balancing rights, risks and needs for services, *Journal of Social Welfare and Family Law*, Vol 23(2), pp. 135-153.
- Hatfield, B., Huxley, P. and Mohamad, H. (1997). Social factors and compulsory detention of psychiatric patients in the UK, *International Journal of Law and Psychiatry* Vol 23(2), pp. 389-397.
- Hatfield, B., Mohamad, H. and Huxley, P. (1992). The 1983 Mental Health Act in five local authorities: A study of the practice of approved social workers, *International Journal of Social Psychiatry*, Vol. 38(3), pp. 189-207.
- Haynes, R. (1990). After 1983: Approved Social Workers' perceptions of their changing role in emergency psychiatric assessments, *Practice: Social Work in Action*, Vol. 4(3), pp. 184-198.
- Health and Care Professions Council (2013). *Approval criteria for Approved Mental Health Professional (AMHP) programmes*, London: Health and Care Professions Council.
- Her Majesty's Government (2008). *The Mental Health (Approved Mental Health Professionals) (Approval) (England) Recommendations*, London: Her Majesty's Government.
- Hochschild, A. R. (1983). *The Managed Heart: Commercialisation of human feeling*, Berkeley: University of California Press.
- Houston, S. and Mullan-Jensen, C. (2011). Towards depth and width in qualitative social work: Aligning interpretative phenomenological analysis with the theory of social domains, *Qualitative Social Work*, Vol 11(3), pp. 266-281.

- Hudson, J. and Webber, M. (2012). *The National AMHP survey 2012 final report. Stress and the statutory role: is there a difference between different professional groups*, London: Kings College.
- Hughes, E. (1971). *The Sociological Eye: Selected papers*, Chicago: Aldine Atherton.
- Hurley, J. and Linsley, P. (2007). Expanding roles within mental health legislation: an opportunity for professional growth or a missed opportunity? *Journal of Psychaitric and Mental Health Nursing*, Vol. 14, pp. 535-541.
- Hus, E. (2012). What we see and what we say: combining visual and verbal information within social work research, *British Journal of Social Work*, Vol 42, pp. 1440-1459.
- Huxley, P., Evans, S., Webber, M. and Gately, C. (2005). Staff shortages in the mental health workforce: the case of the disappearing Approved Social Worker, *Health and Social Care in the Community*, Vol 13(6), pp. 504-513.
- Huxley, P. and Kerfoot, M. (1994). A Survey of Approved Social Work in England and Wales, *British Journal of Social Work*, Vol 24, pp. 311-324.
- Huxley, P. Evans, S., Gately, C., Webber, M., Mears, A., Pajak, S., Kendall, T., Medina. J. and Katona. C. (2005). Stress and pressures in mental health social work: The worker speaks, *British Journal of Social Work*, Vol. 35, pp. 1063-1079.
- Kearney, K.S. and Hyle, A.E. (2004). Drawing out emotions: the use of participant-produced drawings in qualitative inquiry, *Qualitative Research*, Vol 4, pp. 361-382.
- Kitwood, T. (1990). *Concern for 'others'*, London: Routledge.
- Kitwood, T. (1997). *Dementia reconsidered*, Buckingham: Open University Press.
- Knott, G and Bannigan, K. (2013). A critical review of the Approved Mental Health Professional role, *British Journal of Occupational Therapy*, Vol 76(3), pp. 118-126
- Kvale, S. (2007). *Doing interviews*, London: Sage.
- Larkin, M., Watts, S. and Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis, *Qualitative Research in Psychology*, Vol 3, pp. 102-120.
- Lizardo, O. (2012). The conceptual bases of metaphors of dirt and cleanliness in moral and non-moral reasoning, *Cognitive Linguistics*, Vol. 23(2), pp. 367-393.
- Maclure, M. (2005). 'Clarity bordering on stupidity': where's the quality in systematic review? *Journal of Education Policy*, Vol 20(4), pp. 393-416.
- Manktelow, R., Hughes, P., Britton, F., Campbell, J., Hamilton, B. and Wilson, J. (2002). The experience and practice of Approved Social Workers in Northern Ireland, *British Journal of Social Work*, Vol. 32, pp. 443-461.

Matthews, S. (2013). Using drawing to generate data: Exploring the role and experiences of Approved Mental Health Professionals, *Sage Research Case Methods*, London: Sage.

Matthews, S., O'Hare, P. and Hemmington, J. (2014). *Approved Mental Health Practice: Essential themes for students and practitioners*. Basingstoke: Palgrave MacMillan.

Mays, N., Pope, C. and Popay, J. (2005). Systematically reviewing qualitative and quantitative evidence to inform management and policy making in the health field, *Journal of Health Services Research and Policy*, Vol 10(1), pp. 6-20.

Mental Treatment Act (1930). London: HMSO

Mental Health Act (1959). London: HMSO

Mental Health Act (1983) as amended by Mental Health Act (2007). London: HMSO

McCormack, B. (2004). Person-centredness in gerontological nursing: An overview of the literature, *Journal of Clinical Nursing*, Vol 13, pp. 31-38.

McCrae, N., Murray, J., Huxley, P. and Evans, S (2004). Prospects for mental health social work; a qualitative study of attitudes of service managers and academic staff, *Journal of Mental Health*, Vol. 13, issue 3 pp. 305-318.

McNicol, A. (2016). Warning over 'severe' AMHP shortages as hundreds leave, *Community Care*, September 7<sup>th</sup>.

Miles, H.L., Loudon, J.B. and Rawnsley, K. (1961). Attitudes and practice of mental welfare officers. *Public Health*, Vol. 76 pp. 32-47.

Morriss, L. (2014). *Accomplishing social work identity in interprofessional mental health teams following the implementation of the Mental Health Act, 2007*, United Kingdom: University of Salford: unpublished doctoral thesis.

Morriss, L. (2015). AMHP work: dirty or prestigious? Dirty work designations and the Approved Mental Health Professional, *British Journal of Social Work*, Vol. 46(3), 703-718.

Myers, F. (1999). Social Workers as Mental Health Officers: Different Hats. Different Roles? in *Mental Health and Social Work* in Ulas, M. and Connor, A. (eds), London: Jessica Kingsley

Nathan, J. and Webber, M. (2010). Mental health social work and the bureaucratisation of mental health care: Identity in a changing world, *Journal of Social Work Practice*, Vol. 24 Issue 1 pp. 15-28.

National Institute for Mental Health in England (2008). *Mental Health Act 2007 New Roles*, London: National Institute for Mental Health in England.

National Health Service Act (2006). London: HMSO



- Olsen, M. (1984). *Social Work and Mental Health: A guide for the Approved Social Worker*, London: Tavistock.
- Pargiter, R. and Hodgson, T.D (1959). The mental welfare officer and the psychiatrist, *The Lancet*. Vol. 274 pp. 727-728.
- Parker, J. (2010). Approved Social Worker to Approved Mental Health Professional: evaluating the impact of changes within education, *The Journal of Mental Health Training, Education and Practice*, Vol 5(2), pp. 19 -26.
- Prior, P. (1992). The Approved Social Worker: Reflections on origin,. *British Journal of Social Work*, Vol. 22, pp. 105-109.
- Puddephatt, J. (2006). Special: An interview with Kathy Charmaz: On Constructing Grounded Theory, *Qualitative Sociology Review*, Vol II(3), pp. 5-20.
- Quereshi, H. (2004). Evidence in policy and practice: what kind of research designs, *Journal of Social Work* 4(1), pp. 7-23.
- Quirk, A. (2008). *Obstacles to shared decision-making in psychiatric practice: Findings from three observational studies*, United Kingdom: Brunel University: unpublished doctoral thesis.
- Quirk, A., Lelliott, P., Audini. B. and Buston, K. (2000). *Performing the Act: A qualitative study of the process of mental health act assessment*, London: Department of Health.
- Raineri, M.L. and Cabiati, E. (2015). Kitwood's thought and relational social work, *European Journal of Social Work* ,Vol DOI: 10.1080/13691457.2015.1074549 pp 1-17.
- Rapaport, J. (2006). New Roles in Mental Health, *Journal of Integrated Care* ,14(5), pp. 37-46.
- Rawls, A.W. (2002). Editor's introduction in H. Garfinkel *Ethnomethodology's program: working out Durkheim's aphorism*, Lanham: MA Roman and Littlefield.
- Regehr, C. Stern, S. and Shlonsky, A. (2007). Operationalising evidence based practice: the development of an institute for evidence based social work, *Research on Social Work Practice*, 17(3), pp. 408-416.
- Reid, K., Flowers, P. and Larkin, M. (2005). Exploring Lived Experience. *The Psychologist*, Vol 18(1), pp. 20-23.
- Rolph, S., Atkinson, D. and Walmsley, J. (2003) 'A pair of stout shoes and an umbrella': the role of the Mental Welfare Officer in delivering community care in East Anglia: 1946 – 1970 *British Journal of Social Work* Vol 33 pp 339 -359.
- Rozas, L.W. and Klein, W.C. (2010). The value and purpose of the traditional qualitative literature review, *Journal of evidence-based social work* , Vol 7(5), pp. 387-389.

- Sackett, D.L., Rosenberg, W.M.C., Gray, J.A.M., Haynes, R.B., and Richardson, W.S. (1996). Evidence based medicine: what it is and what it isn't, *British Medical Journal*, Vol 312, pp. 71-72.
- Schon, D.(1983). *The reflective practitioner*, San Francisco: Harper Collins.
- Seebohm, F. (1968) *Report of the committee on local authority and allied personal Social services*. London: HMSO.
- Sheldon, B. (2001). The validity of evidence-based practice in social work: a reply to Stephen Webb, *British Journal of Social Work*, Vol 31, pp. 801-809.
- Sheppard, M. (1990). *Mental Health: The role of the Approved Social Worker*, Sheffield: Joint Unit for Social Service Research.
- Sheppard, M. (1993). Theory for Approved Social Work: the use of the Compulsory Assessment Schedule, *British Journal of Social Work*, Vol 23, pp. 231-237.
- Shaw, R. (2011). The future's bright: celebrating its achievements and preparing for the challenges ahead in IPA research, *Health Psychology Review*, Vol 5(1), pp. 28-33.
- Shinebourne, P. (2011). The theoretical underpinning of interpretative phenomenological analysis (IPA), *Existential Analysis*, Vol 22(1), pp. 16-30.
- Smith, J.A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology, *Psychology and Health* Vol 11, pp. 261-271.
- Smith, J.A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative psychology, *Qualitative Research in Psychology*, Vol 1, pp. 39-54.
- Smith, J.A. (2007). Hermeneutics, human sciences and health: linking theory and practice, *International Journal of Qualitative Studies on Health and Well-being*, Vol 2(1), pp. 3-11.
- Smith, J.A. (2010). Interpretative Phenomenological Analysis: a reply to Amedeo Giorgi, *Existential Analysis*, Vol 21(2), pp.186-192.
- Smith, J.A. (2011a). Evaluating the contribution of interpretative phenomenological analysis, *Health Psychology Review*, Vol 5, pp .9-27.
- Smith, J.A. (2011b). Evaluating the contribution of interpretative phenomenological analysis: a reply to the commentaries and further development of criteria, *Health Psychology Review*, Vol 5(1), pp. 55-61.
- Smith, J.A. (2011c). 'We could be diving for pearls': the value of the gem in experiential qualitative psychology, *Qualitative Methods in Psychology, Bulletin*, Issue 12 .October.
- Smith, J. A. and Osborn, M. (2003). Interpretative Phenomenological Analysis in J.A. Smith (ed.), *Qualitative Psychology: A Practical Guide to Methods*, London: Sage.

- Smith, J.A., Flowers, P. and Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*, London: Sage
- Social Care Institute of Excellence (2010). *Systematic research reviews: guidelines*, London: Social Care Institute of Excellence.
- Stanley, L. and Temple, B. (1995). 'Doing the business? Evaluating Software Packages to aid the analysis of qualitative data sets in R. G. Burgess (ed.) *Studies in Qualitative Methodology: Computing and Qualitative Research*, Vol 5, London: JAI Press.
- Starks, H. and Trinidad, S.B. (2007). Choose your method: A comparison of Phenomenology, Discourse Analysis, and Grounded Theory, *Qualitative Health Research*, Vol 17(10), pp. 1372-1380.
- Strauss, A. and Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*, London Sage
- Taylor, B., Dempster, M. and Donnelly, M. (2007). Grading gems: appraising the quality of research for social work and social care, *British Journal of Social Work*, 36(2), pp. 335-354.
- The College of Social Work, (2014). *The role of the mental health social worker*, London: The College of Social Work.
- Theron, L., Mitchell, C., Smith, A. and Stuart, J. (2011). *Picturing Research: Drawing as visual methodology*, Rotterdam: Sense.
- Timms, N. (1964). *Psychiatric Social Work in Great Britain (1939-1962)*, London: Routledge and Kegan Paul.
- Todorova, I. (2011). Explorations with interpretative phenomenological analysis in different socio-cultural contexts. Commentary on J. Smith: Evaluating the contribution of interpretative phenomenological analysis, *Health Psychology Review*, Vol 5, (1) pp. 34-38.
- Tufford, L. and Newman, P. (2010). Bracketing in qualitative research, *Qualitative Social Work*, Vol 11(1), pp. 80-96.
- Ulas, M. and Connor, A. (1999). *Mental health and social work*, London: Jessica Kingsley.
- van Manen, M. (1990). *Researching lived experience: Human sciences for an action sensitive pedagogy*, Althouse Press: Ontario.
- van Manen, M. (1998). Modalities of body experience in illness and health, *Qualitative Health Research*, Vol 8(1), pp. 7-24.
- Vicary, S., Young, A., and Hicks, S. (2016). A reflective journal as learning process and contribution to quality and validity in interpretative phenomenological analysis, *Qualitative Social Work*, published online before print February 29, pp. 1-16.
- Wallace, M. and Wray, A. (2011). *Critical reading and writing for postgraduates*, 2nd edn, London: Sage.

Walton, P. (2000). Reforming the Mental Health Act 1983: an Approved Social Worker perspective, *Journal of Social Welfare and Family Law*, Vol. 22(4), pp. 401- 414.

Webb, S. (2001). Evidence-based practice and decision analysis in social work, *Journal of Social Work*, Vol. 2(1), pp. 45-63.

Webber, M (2008). *Evidenced-based practice policy and practice in mental health social work*, Exeter: Learning Matters.

Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in Theory*, Buckingham: Open University Press.

Yardley, L. (2008). Demonstrating validity in qualitative research in J.A. Smith (ed.) *Qualitative psychology: A practical guide to research methods* 2<sup>nd</sup> edn, pp. 235-251 London: Sage.

## APPENDIX ONE

### Literature considered for review but not analysed

Paper retrieved	Reason for exclusion
Allen, C. (2002) Policy <i>Mental Health Practice</i> Vol 6 Issue 2 p 4	This is not reporting primary research. However, it contains an overview of how nurses have responded to proposal to open up the AMHP role and is therefore of relevance to the thesis
Allen, J (2004) Opinion <i>Mental Health Practice</i> Vol 7 issue 5	This is not reporting primary research. However, it provides contemporary opinion on the role of nurses as AMHPs and is therefore of relevance to the thesis
Brown, R. (2002) The Changing role of the Approved Social Worker <i>Journal of Mental Health Law</i> , December 392 2002	This is not primary research. However, it contains a discussion about the impact of reforms of mental health act on ASWs and is therefore of relevance to the thesis
Campbell, J. (2010) Deciding to detain: the use of compulsory mental health law by UK social workers <i>British Journal of Social Work</i> Vol 40 pp 328-334	This is not reporting primary research. However, it contains contextual and theoretical points relevant to the thesis
Doherty, L. (2007) Ready for a new era in mental health <i>Nursing Standard</i> Vol 21 issue 51 p 12	This is not reporting primary research. However, it debates the impact of the new AMHP role for nurses and is therefore of relevance to the thesis
Dwyer, S. (2011) Walking the tightrope of a mental health act assessment <i>Journal of Social Work Practice</i> pp 1-13	This is not reporting primary research. However, it contains theoretical points relevant to the thesis
Du Feu (2012) What did the OT say to the AMHP <i>Professional Social Work</i> June, 2012	This is not reporting primary research. However, it contains a discussion of skills between social workers and occupational therapists in the AMHP role and is therefore relevant to the thesis
Gould, N (2005) An inclusive Approach to Knowledge for Mental Health Social Work Practice <i>British Journal of Social Work</i> Vol 36 pp 109-125	This is not reporting primary research. It proposes a new framework for the identifying the knowledge base for mental health social workers in the context of integration
Hargreaves, R. (2007) The Mental Health Bill 2006 – a social work perspective <i>Journal of Mental Health Law</i> May 2007 85 2007	This is not reporting primary research. However, it contains a discussion of the proposed changes to the Mental Health Act 1983 from a social work perspective and is therefore is of contextual relevance to the thesis
Hurley, J. and Linsley, P. (2007) Expanding roles within mental health	This is not reporting primary research. However, it contains a discussion about

legislation: an opportunity for professional growth or a missed opportunity? <i>Journal of Psychiatric and Mental Health Nursing</i> Vol 14 pp 535-541	the opportunity the new AMHP role might provide to nurses
Jackson, C. (2009) Approved mental health practitioner: taking on the challenge of the role <i>Mental Health Practice</i> Vol 12 Issue 8 pp 22-25	This is not reporting primary research. However, it reports on the take up of various health groups for the AMHP role and debates the challenges. It is therefore of relevance to the thesis
Jordan, R. and Parkinson, C. (2001) Reflective practice in a process for the re-approval of ASWs: an exploration of some inevitable resistance <i>Journal of Social Work Practice</i> Vol 15, issue 1 pp 67-79	This is not reporting primary research. It is a discussion of a proposed new protocol for reapproval of mental health social workers in one London borough. As such it is not relevant to this thesis
Knott, G. and Bannigan, K. (2013) A critical review of the approved mental health professional role and occupational therapy <i>British Journal of Occupational Therapy</i> Vol 76 Issue 3 p 118- 126	This is not primary research. However, it reports a literature review conducted to explore the fit between the AMHP role and occupational therapy and is therefore of direct relevance to the thesis
Mackay, K. (2012) A parting of the ways? The diverging nature of mental health social work in the light of the new Acts in Scotland and in England and Wales <i>Journal of Social Work</i> Vol 12 Issue 2 pp 179- 193	This is not reporting primary research. It discusses the new Acts in Scotland and in England and Wales in terms of the impact of the content on mental health social work in the United Kingdom. It is therefore not of direct relevance to the thesis
McCrae, N., Murray, J., Huxley, P. and Evans, S (2004) Prospects for mental health social work; a qualitative study of attitudes of service managers and academic staff <i>Journal of Mental Health</i> Vol 13 issue 3 pp 305-317	This is primary research. It concerns the future role of social work as a distinct discipline and is not directly relevant to the thesis
McKenna, B.G., O, Brien, A.J., Dal Din, T., and Thom, K. (2006) Registered nurses as responsible clinicians under the New Zealand Mental Health (Compulsory Assessment and Treatment) ACT 1992 <i>International Journal of Mental Health Nursing</i> Vol 15, pp 128-134	This is primary research. It applies to a country outside of the United Kingdom
McLaughlin, K. (2001) Fear, risk and mental health: observations on policy and practice <i>Practice; social work in action</i> Vol 3 issue 3 pp 55-64	This is not primary research. It discusses the reform of the Mental Health Act 1983 and the changes in the context of risk avoidance. It is not directly relevant to the thesis
McNicoll, A. (2012) One in five AHMPs wants to quit role amid 'unacceptably	This is not primary research. However, it reports on an primary study so is of interest to the thesis

high' stress levels <i>Community Care</i> 4 <sup>th</sup> October	
McNicoll, A. (2013) AMHP numbers fall at two fifths of councils despite rising demand for support <i>Community Care</i> 26 March	This is not primary research. However, it reports findings from a Freedom of Information request explaining shortages of AMHP numbers in some areas. It is of some relevance to the context of this thesis
McNicoll, A. (2013) Drop in numbers of social workers funded to train as AMHPs <i>Community Care</i> 9 <sup>th</sup> April	This is not primary research. However, it discusses data about numbers of AMHPs declining and the impact this might have on their ability to undertake the work. It is therefore of contextual relevance to the thesis
McNicoll, A. (2013) Emergency mental health admissions delayed up to 3 weeks due to beds crisis, social workers warn <i>Community Care</i> 1 <sup>st</sup> June	This is not primary research. However, it discusses pressures on AMHPs and their ability to undertake the role so is therefore of relevance to this thesis
Nathan, J and Webber, M. (2010) Mental Health Social Work and The Bureau-Medicalisation of Mental Health Care: Identity In a Changing World <i>Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community</i> Vol 24 Issue 1 pp 15-28	This is not primary research. It discusses mental health social work in the context of changes in the National Health Service and is therefore not of direct relevance to the thesis
O'Brien, A., and Calderwood, K.A. (2010) Living in the shadows: A Canadian Experience of Mental Health Social Work <i>Social Work in Mental Health</i> Vol 8 Issue 4 pp 319-335	This is primary research but does not apply to the United Kingdom
Parkinson, C. and Thompson, P (1998) Uncertainties, mysteries, doubts and Approved Social Worker Training <i>Journal of Social Work Practice</i> Vol 12 issue 1 pp 57-64	This is not primary research. However, it contains a discussion of the psycho therapeutic aspects of approved mental health practice so if of relevance to the thesis
Prior, P.M (1992) The Approved Social Worker – Reflections on Origins <i>British Journal of Social Work</i> Vol 22 Issue 2 p 105 -119	This is not primary research. However, it contains theoretical points of relevance to the thesis
Rapaport, J. (2006) New roles in Mental Health: The Creation of the Approved Mental Health Practitioner <i>Journal of Integrated Care</i> Vol 14 Issue 5 pp 37- 46	This is not primary research. However, it contains a discussion about the implications of the introduction of the AMHP role for the workforce and is therefore of direct relevance to the thesis
Rapaport, J. and Manthorpe, J. (2008) Putting it into Practice: Will the new Mental Health Act slow down or accelerate integrated working? <i>Journal of Integrated Care</i> Vol 16 issue 4 pp	This is not primary research. However, it contains a discussion on the possible impact of opening up the AMHP role and is therefore of relevance to the thesis

Thompson, P. (1997) Approved social work and psychotherapy <i>Practice: social work in action</i> Vol 9 issue 2 pp 35-46	This is not primary research. However, it discusses from a psychotherapeutic viewpoint the role of approved mental health practitioners so is of direct relevance to the thesis
Thompson, P (1997) Practice at the outer limits of approved social work <i>Practice: social work in action</i> Vol 9 issue 4 pp 57-65	This is not primary research. However, it discusses the practice of approved mental health practitioners from a psychotherapeutic viewpoint so it of direct relevance to the thesis
Thompson, P (2003) Devils and deep blue seas: the social worker in-between <i>Journal of Social Work Practice</i> Vol 17 Issue 1 pp 35- 47	This is not primary research. However, it explores the impact of approved mental health practice on workers integrating viewpoints within a psychoanalytical perspective so is of direct relevance to the thesis
Walton, P. (1999) Social work and mental health: refocussing the training agenda for ASWs <i>Social Work Education</i> Vol 18, Issue 5 pp 375-388	This is not primary research. However, it discusses the role of the competence framework for approved mental health practitioners so is of some relevance to the thesis
Webber, M. (2012) How the latest Mental Health Act research should inform social work practice <i>Community Care</i> 30 <sup>th</sup> August	This is not primary research. However, it discusses the latest statistics relating to detention and the consideration of risk for approved mental health practitioners so is of some relevance
Webber, M. (2012) AMHP survey analysis: ‘ a depressingly familiar picture of an undervalued workforce’ <i>Community Care</i> 1 <sup>st</sup> October	This is not primary research. However, it is a press release of primary research into a national survey and is therefore of relevance to the thesis
Weekes, D. (2009) New act, new ethos, new role <i>Nursing standard</i> Vol 24 issue 11 pp62-63	This is not primary research. It discusses reform of legislation from the point of view of nurses and the impact on them. It is therefore of direct relevance to the thesis



## APPENDIX TWO

### Examples of critical synopses and analyses

#### Critical Synopsis of a Text

Quirk et al., 2000 Performing the Act: a qualitative study of the process of Mental Health Act assessments

**a) Why am I reading this?**

This is a report commissioned by Department of Health to provide a better understanding of the process involved in conducting assessments, the role of participants undertaking the assessment and the experience of professionals. It is therefore highly relevant to my thesis

**b) What are the authors trying to do in writing this?**

The authors are reporting the findings of the observations of assessments and in depth interviews with participants in a variety of hospital and community settings. The work was commissioned by the Department of Health to provide an understanding of the process in light of the concurrent review of the Mental Health Act 1983

**c) What are the authors saying that is relevant to what I want to find out?**

They are exploring the process and providing information about the experience of approved mental health practitioners in line with the first objective of my thesis to explore perception of the role and the second which is to determine and understand professional identities as internalised and applied especially in relation to attributes such as skill and values

**d) How convincing is what the authors are saying?**

Highly. The research is reported according to robust processes

**e) In conclusion, what use can I make of this?**

That this work needs careful analysis

## **Critical Analysis of a Text**

**Text: Quirk et al., (2000)**

Performing the Act: a qualitative study of the process of Mental Health Act assessments

### **1. What review question am I asking of this text?**

(e.g. what is my research question? why select this text? does the Critical Analysis of this text fit into my investigation with a wider focus? what is my constructive purpose in undertaking a Critical Analysis of this text?)

This text will provide qualitative evidence to understand approved mental health practitioners' perception of their role in line with my first objective and also to understand professional identities as internalised and applied by approved mental health practitioners including in relation to attributes such as skills and values which is in line with my second objective

### **2. What type of literature is this?**

(e.g. theoretical, research, practice, policy? are there links with other types of literature?)

This is research commissioned by the Department of Health to provide knowledge of the assessment process in light of the review of the Mental Health Act 1983. Links are made with relevant theory and contemporary research

### **3. What sort of intellectual project for study is being undertaken?**

- a) How clear is it which project the authors are undertaking? (e.g. knowledge-for-understanding, knowledge-for-critical evaluation, knowledge-for-action, instrumentalism, reflexive action?)

This is a knowledge for understanding project

- b) How is the project reflected in the authors' mode of working? (e.g. a social science or a practical orientation? choice of methodology and methods? an interest in understanding or in improving practice?)

This has a practical orientation using qualitative methods combining observations and in-depth interviews to understand the processes involved in conducting assessments, the role of participants and the experiences of professionals. It also tries to understand the experiences of patients and carers but this is not relevant to my thesis.

- c) What value stance is adopted towards the practice or policy investigated? (e.g. relatively impartial, critical, positive, unclear? what assumptions are made about the possibility of improvement? whose practice or policy is the focus of interest?)

The research, despite being commissioned by the Department of Health for a specific purpose, is nonetheless impartial. The practice which is the focus of the interest is approved mental health practice and the policy is the review of mental health legislation in England and Wales.

- d) How does the sort of project being undertaken affect the research questions addressed? (e.g. investigating what happens? what is wrong? how well does a particular policy or intervention work in practice?)

The project seeks to understand what happens during a mental health act assessment

- e) How does the sort of project being undertaken affect the place of theory? (e.g. is the investigation informed by theory? generating theory? atheoretical? developing social science theory or a practical theory?)

No theories are developed.

Rather, a series of recommendations are made. Of the ones that apply to my thesis;

- The first is that more qualitative work should inform developments in mental health policy;
- Second, future mental health professionals will require training for this demanding and multi-dimensional role.
- Third; social workers have much experience and it will not easily be adopted by other professionals (but, that is not to say that they cannot do it).
- Fourth; the process (and the person leading this) must be an effective organiser and stage-manager.
- Fifth; the social work role must be safeguarded so that the person's lifestyle and identity are given due weight.
- Sixth, the approved mental health practitioner cannot carry out all roles effectively particularly that of advocate
- Last, consideration should be given as to how relationships between professionals can be improved

- f) How does the authors' target audience affect the reporting of research? (e.g. do they assume academic knowledge of methods? criticize policy? offer recommendations for action?)

The report's aim is to inform the making of government policy and is therefore provides a number of recommendations for action

#### 4. What is being claimed?

- a) What are the main kinds of knowledge claim that the authors are making? (e.g. theoretical knowledge, research knowledge, practice knowledge?)

Research knowledge to understand practice;

- Mental health act assessments are made up of three stages: the build-up, the assessment and the aftermath (p.5) but, this belies the everyday ambiguities and complexities which are commonly subject to false starts, disruptions, delays and no shows. Ambiguity surrounding the formal starting point only being seen as such in retrospect. Much informal assessment can take place during the build-up particularly when known clients are involved. This can be done to such an extent that professionals carry into the assessment a clear expectation of the likelihood of compulsory admission (needs checking). Not a blank slate, more likely to run with an hypothesis which is constantly tested throughout the assessment. NB the three stage process reflects the professional perspective
- ASWs require expertise in 'ongoing contingency management' Task juggling and improvisation, cajoling and persuasion are typically required to get various busy professionals to the same place at the same time (p.6)
- Information is shared between professionals in the build-up. CPN sometimes lobby on behalf of known clients.
- Professional-client interaction characterised by different levels of formality (police cell diff to person's own home)
- The 'feel' of an assessment can be influenced by the pace at which it is conducted. Some assessments made on a comprehensive mental state examination. Others on the spot once glaring evidence of a mental disorder

- ASWs have multiple perceived roles during assessments, including applicant, social worker, care manager, advocate, hate figure, bureaucrat, (social) policemen-executioner, ongoing contingency manager and impresario (stage manager). There can sometimes be tensions between these roles
- In one of the boroughs there was a culture of viewing hospital admission as a last resort. Other more pragmatic depending on resources
- Support varies. One borough discussed assessments routinely. One way in which treatment ideologies or organisational cultures are communicated and sustained
- ASWs derive satisfaction from having done a job well, but rarely view an admission as a good piece of work (how does this compare with mine. Nurse says the outcome (an admission is good). Do social workers. Do OTs?
- ASWs have a significant stock of knowledge that extends well beyond their knowledge of the Act itself. Any professionals in the future will require training for this demanding and multi-dimensional role. The stage management and this will not easily be adopted by other professionals (does not say upon what this is based). Views two of the roles social worker and bureaucrat as especially important (what is this based on) but social role means person's lifestyle and identity are given due weight. Multiple roles are of concern as it causes confusion in the mind of people being assessed and future therapeutic relationships (upon what do they base this). Role of guarantor of person's rights eroded in some teams to the point where some feel they have little true independence in decision-making (what is this based on?). Calls for an independent advocate (how is this conclusion reached)
- Various professionals come into the orbit of a MHA assessment. For each the experience is quite different (p.10) and rests on different priorities and arise from diff organisational cultures, but these are exacerbated where resources are scarce. How can relationships between prof groups be improved (does this ignore the tension is needed)

- b) What is the content of the main claims to knowledge and of the overall argument? (e.g. what, in a sentence, is being argued? what are the three to five most significant claims that encompass much of the detail? are there key prescriptions for improving policy or practice?)

The report claims that the assessment process has three stages in which approved mental health practitioners undertake various roles between which there is sometimes tension.

The various roles can cause confusion for the person being assessed and may impact on the therapeutic relationship. The most important roles as defined by the authors are said to be that of social worker (assessing social circumstances and bureaucrat (the need to follow the rules)

Knowledge which approved mental health practitioners require is not just legal. They also require expertise in ongoing contingency management and skills in task juggling, improvisation, cajoling and persuasion.

Orchestrate

Each professional experiences the process differently as a result of organisational priorities and cultures

- c) How clear are the authors' claims and overall argument? (e.g. stated in an abstract, introduction or conclusion? unclear?)

The claims are stated in a recommendations and conclusion section and are clear

- d) With what degree of certainty do the authors make their claims? (e.g. do they indicate tentativeness? qualify their claims by acknowledging limitations of their evidence? acknowledge others' counter-evidence? acknowledge that the situation may have changed since data collection?)

The authors acknowledge that generalisability might be questioned given the nature of the study, but also state that there were a relatively large number of workers involved so this could be defended. They also defend the choice of sites used because they differ substantially (but were both still London boroughs). No further limitations are discussed either in relation to the sampling, the data collection, or the analysis

- e) How generalized are the authors' claims – to what range of phenomena are they claimed to apply? (e.g. the specific context from which the claims were derived? other similar contexts? a national system? a culture? universal? implicit? unspecified?)

The claims can, with some caution, be generalised, albeit there is a specific geographical setting which may not easily be replicated elsewhere plus there are local service factors which influence style of working

- f) How consistent are the authors' claims with each other? (e.g. do all claims fit together in supporting an argument? do any claims contradict each other?)

The claims refer to different aspects. I have picked out those that apply to the way in which the role is experienced by the person leading the assessment namely as this is the focus of my thesis, but there are further claims concerning the use of the mental health act between areas and the impact on decisions made, the impact of the assessment process on the person being assessed and their carers and suggestions for future developments for all professionals

## 5. To what extent is there backing for claims?

- a) How transparent is it what, if any, sources are used to back the claims? (e.g. is there any statement of the basis for assertions? are sources unspecified?)

The claims are based on the data from the study. The data used are the contemporaneous field notes of the researcher doing the observation and also derived from follow up interviews with individual staff which were audio-taped. Data analysis followed a grounded theory approach in that data collection and analysis proceeded simultaneously. Further data collected following on-going analysis which provided further ideas to explore. Thereby modifying and testing these.

- b) What, if any, range of sources is used to back the claims? (e.g. first-hand experience? the authors' own practice knowledge or research? literature about others' practice knowledge or research? literature about reviews of practice knowledge or research? literature about others' polemic?)

The context to the study is presented as is a defence of the methodology but no other theory or knowledge is used to discuss the claims being made

- c) If claims are at least partly based on the authors' own research, how robust is the evidence? (e.g. is the range of sources adequate? are there methodological limitations or flaws in the methods employed? do they include cross-checking or 'triangulation' of accounts? what is the sample size and is it large enough to support the claims being made? is there an adequately detailed account of data collection and analysis? is a summary given of all data reported?)

The evidence to back up the claims are direct quotes from participants or excerpts from the observer's own field notes. These do back claims, but are not universally applied. There is detail of the ethical considerations, sampling strategy, data collection and analysis. Sample size is adequate given the methodology. Several team members analysed the data to identify salient issues and inform further data collection. Draft and final reports were circulated to a selection of participants for their views on the content and accuracy.

- d) Are sources of backing for claims consistent with degree of certainty and the degree of generalization? (e.g. is there sufficient evidence to support claims made with a high degree of certainty? is there sufficient evidence from other contexts to support claims entailing extensive generalization?)

Given the methodology, there is sufficient evidence to support the claims with a high degree of certainty

**6. How adequate is any theoretical orientation to back claims?**

- a) How explicit are the authors about any theoretical orientation or conceptual framework? (e.g. is there a conceptual framework guiding data collection? is a conceptual framework selected after data collection to guide analysis? is there a largely implicit theoretical orientation?)

There is a conceptual framework guiding sampling, data collection and analysis

- b) What assumptions does any explicit or implicit theoretical orientation make that may affect the authors' claims? (e.g. does a perspective focus attention on some aspects and under-emphasize others? if more than one perspective is used, how coherently do the different perspectives relate to each other?)

No assumptions are made to affect the authors' claims and no particular emphasis detected

- c) What are the key concepts underpinning any explicit or implicit theoretical orientation? (e.g. are they listed? are they stipulatively defined? are concepts mutually compatible? is use of concepts consistent? is the use of concepts congruent with others' use of the same concepts?)

There is no theoretical stance identified nor concepts used

**7. To what extent does any value stance adopted affect claims?**

- a) How explicit are the authors about any value stance connected with the phenomena? (e.g. a relatively impartial, critical, or positive stance? is this stance informed by a particular ideology? is it adopted before or after data collection?)

This is an impartial stance driven by the aim to provide knowledge of a certain phenomenon, the process of mental health act assessments

- b) How may any explicit or implicit value stance adopted by the authors affect their claims? (e.g. have they pre-judged the phenomena discussed? are they biased? is it legitimate for the authors to adopt their particular value stance? have they over-emphasized some aspects of the phenomenon while under-emphasizing others?)

No bias is detected

**8. To what extent are claims supported or challenged by others' work?**

- a) Do the authors relate their claims to others' work? (e.g. do the authors refer to others' published evidence, theoretical orientations or value stances to support their claims? do they acknowledge others' counter-evidence?)

The claims are not related to the work of others either to support or counteract them.

- b) If the authors use evidence from others' work to support their claims, how robust is it? (e.g. as for 5c)

Not used

- c) Is there any evidence from others' work that challenges the authors' claims, and if so, how robust is it? (e.g. is there relevant research or practice literature? check any as for 5c)

There is evidence to support the claims e.g. Bowers et al. Ulas?

**9. To what extent are claims consistent with my experience?**

The claims are consistent with my personal practice experience and are also reflected in my research

**10. What is my summary evaluation of the text in relation to my review question or issue?**

**a) How convincing are the authors' claims, and why?**

They are convincing because the research process is clearly explained and use is made of data to illustrate claims albeit not universally.

**b) How, if at all, could the authors have provided stronger backing for their claims?**

The claims could have been strengthened by comparing them with existing research and theoretical concepts

### **Critical Synopsis of a Text**

**Bowers et al. Multidisciplinary reflections on...**

**a) Why am I reading this?**

Empirical research which reports the views of the range of professionals involved in an assessment under the Mental Health Act 1983 and is therefore directly relevant to my thesis

**b) What are the authors trying to do in writing this?**

The authors are reporting the results of interviews from a convenience sample of doctors (8), Approved Social Workers (5), community psychiatric nurses (5) ambulance personnel (5) and police (8) in order to explore how the assessment and detention process works.

**c) What are the authors saying that is relevant to what I want to find out?**

They are trying to explore themes concerning the assessment and detention process across all disciplines and to those which were unique to one or two professional groups only

**d) How convincing is what the authors are saying?**

This is a research note which provides some detail about the sampling process, but very little about the collection or analysis process. Also, there is no mention of the ethical process. Six themes are reported in their findings followed by a brief discussion

**e) In conclusion, what use can I make of this?**

The themes are of interest to my thesis as they concern approved mental health practice, but the write up does not allow judgement about the robustness. There is a direct quote, albeit unattributed, which is of interest



### **Critical Analysis of a Text**

**Text:**

Bowers et al (2003)

**1. What review question am I asking of this text?**

This text might help me understand the perception by professionals involved in an assessment, of the role of an approved mental health practitioner and to give some insight into the determination and understanding of professional identities including in relation to such attributes as skills and values

**2. What type of literature is this?**

This is a research note reporting the findings of analysis of interviews undertaken with a convenience sample of multidisciplinary professionals involved in the assessment process. The authors refer to a study that was undertaken by Ulas et al in Scotland some ten years earlier which they regard as a 'rare exception'. However, exactly one such study commissioned by the Department of Health had been published at that time Quirk et al (2000) which leads me to question the rigour of the contextual work especially as the companion study is cited (Hotopf et al)

**3. What sort of intellectual project for study is being undertaken?**

a)

The research aims to provide knowledge about the assessment process, specifically from the viewpoint of the various professionals involved

b)

The research is conducted by a psychiatrist nurse and two members of a research team now researching conflict and containment in psychiatry. It has a practical orientation interested in understanding practice which takes place during an assessment

c)

It arises from the authors' interest in coercion and the irony according to them that people admitted formally feeling less coerced than those admitted 'voluntarily'. The aim is to explore how the assessment and detention process works in the light of the increased numbers of compulsory admissions and interest in the determinants of compulsory admission which concern severity of symptoms, social reasons and service factors

d)

This research provides an insight into the views of the professional involved with a view to investigating what happens during an assessment.

Findings are:

**Organising an assessment**

- It is difficult to get requested personnel to the right place at the right time and the delay in any member's arrival could mean that the admission could not proceed. An unattributed quote is used to illustrate this and denotes spinning plates. (I suspect this is an ASW)

- there is a need to act quickly once the decision to admit has been taken driven by the concern that the patient would become aggressive or run away
- Doctors report practical difficulties – of getting everyone in the right place at right time and of person then absconding. Doctors also report the difficult of making a judgement either of the potential for deterioration and that the person might present well. One doctor spoke of potential for violence
- All ASWs spoke of difficulties of assembling the correct professional (in response to question ‘what problems typically arise?’).

#### **Violence**

- Ambulance personnel said there were very few problems other than the person becoming aggressive. Police mentioned time as an issue
- Large potential for endangering worker safety but no example given of physical violence. Screaming and shouting are examples of the process being unpleasant. Physical resistance making process more confrontational – not clear which participant was saying this
- No ASW had been hit during an assessment. One ‘threatened regularly’ another ‘violence doesn’t happen often’. Aggression due to mental state or fear of what was happening. Used calming strategies such as explaining the process and speaking quietly to reduce arousal and fear
- Doctors had mostly experienced frightening situations but their appraisal differed between consultant and family physician. Violence due to symptoms fear and invading personal space. Used common sense strategies such as quietly speaking, showing respect and trying not to overcrowd small rooms
- Not mentioned by CPNs until asked when they said verbal aggression and threatening behaviour seen regularly.
- Police say client becomes violent; currently violent and potentially violent

#### **Impact on patient**

- Interviewees were asked about damage to therapeutic relationship (as speculated by research team). Doctors, nor ASWs said not. CPNs said yes and gave examples but, one said being there for someone can strengthen the therapeutic alliance

#### **Skills and training**

- Doctors – team work, assessment skills, building relationships, using persuasion
- ASWs – gathering and assessing information, organising, communication, building rapport and keeping things calm
- CPNs communication listening, risk assessment, de-escalation, involving carers and family
- Ambulance – reassurance, patience, explaining what is going to happen, building trust (through eye contact and negotiation)

#### **Where skills learnt**

- Doctors - said none in medical school and wanted shadowing (as ASW students do)
- ASWs – skills learnt through observation and experience. Learnt by doing. Training good, but too short
- CPNs – experience
- Ambulance – not much
- Police – not much

- e) How does the sort of project being undertaken affect the place of theory? (e.g. is the investigation informed by theory? generating theory? atheoretical? developing social science theory or a practical theory?)

This is atheoretical

- f) How does the authors’ target audience affect the reporting of research? (e.g. do they assume academic knowledge of methods? criticize policy? offer recommendations for action?)

The article is published in a journal aimed at social work practitioners and academics and makes a number of recommendations concerned with the importance of interprofessional training for a procedure that requires 'true' multidisciplinary team work, or, assessments

**4. What is being claimed?**

- a) What are the main kinds of knowledge claim that the authors are making? (e.g. theoretical knowledge, research knowledge, practice knowledge?)

The authors are making practice knowledge concerning the process of assessment;

- The practicalities of getting all the right people at the right time. The incidence of repeat visits which come about because previous interventions had been attempts to admit the person informally but the situation had deteriorated. Suggested that reducing the number of people needed to admit might ameliorate this, but accepted that client's right might be compromised
- Incidence of aggression and violence of great concern to staff attending assessments in the community, especially verbal aggression and feeling threatened. Only police seem to receive training in breakaway techniques. Neither social workers nor doctors appear to do so
- Break in therapeutic relationship especially with doctor was rare following an assessment only where this has not been good previously. CPNs were group most concerned with impact of involvement which the authors find interesting as they point out that CPNs have no statutory role in the process
- Even though all skills were present, no formal training in managing assessment for compulsory admission as was absent. Interprofessional training is therefore recommended, agreeing with Harrison (1996)

- b) What is the content of the main claims to knowledge and of the overall argument? (e.g. what, in a sentence, is being argued? what are the three to five most significant claims that encompass much of the detail? are there key prescriptions for improving policy or practice?)

The authors main claims are:

- That the assessment process involves practical considerations which can affect the status of the admission and suggest that less people in the process should be considered albeit, this might impact adversely on the person's rights.
- That professionals involved in assessments in the community should receive breakaway training and that interprofessional training concerning the process would be beneficial
- There is little impact on the therapeutic relationship for doctors but CPNs even though they did not have a statutory role when this research was undertaken, feared that it might

- c)

These claims are made in the discussion section

- d)

No qualification or limitations to the study are stated nor do they compare with other studies

- e)

The claims arise from the specific context of an assessment for compulsory admission

- f)

The claims concern two separate matters; the impact of practicalities on the process of admission with qualified suggestions made to ease this for professionals. Second that professionals would benefit from training in

breakaway techniques to aid safety and interprofessional training in the assessment process specifically. The claims arise from the analysis of the qualitative data, but this process of analysis is not explained and it is not possible to reach such conclusions from the data which is presented. Also, ASWs receive in depth training. No mention is made of this. Nor, does the article refer to already published research on this exact process.

**5. To what extent is there backing for claims?**

- a) How transparent is it what, if any, sources are used to back the claims? (e.g. is there any statement of the basis for assertions? are sources unspecified?)

No sources are used to back the claims other than the data.

- b)

No sources are used to back the claims

- c) If claims are at least partly based on the authors' own research, how robust is the evidence? (e.g. is the range of sources adequate? are there methodological limitations or flaws in the methods employed? do they include cross-checking or 'triangulation' of accounts? what is the sample size and is it large enough to support the claims being made? is there an adequately detailed account of data collection and analysis? is a summary given of all data reported?)

The account of data collection is adequate. The sample is a convenience one justified due to pressures of time for potential participants and the idea that informants who are willing to participate have more to offer.

Interviews were based on a semi-structured format developed by the research team, but this is not included. Notes of responses were taken by the interviewer. There is no mention made of the practical difficulties of interviewing, listening and taking notes at the same time. There is also a potential that the notes made might be biased – the note taker picking up on their own perceptions

- d)

The claims are based on the qualitative data only. Given the concerns regarding data collection and the lack of information concerning the analysis process they should be treated with a degree of caution. The aim was to identify themes across all disciplines and also those unique to one or two professional groups only albeit, no reason was given for doing this.

**6. How adequate is any theoretical orientation to back claims?**

- a)

There is no theoretical orientation other than to place the research in the context of increased numbers of admissions and interest in reasons for admissions concerning severity of symptoms and also social and service reasons. There is an implicit acceptance that compulsory admission is a process which is not a contested one per se, albeit the process can be improved.

- b) What assumptions does any explicit or implicit theoretical orientation make that may affect the authors' claims? (e.g. does a perspective focus attention on some aspects and under-emphasize others? if more than one perspective is used, how coherently do the different perspectives relate to each other?)

The implicit assumptions affect the claim that the process could be improved to make it 'better' for the professionals involved

c)

The key concept is that compulsory admissions for the person can involve coercion but especially so where there is a voluntary admission. The need for admission is not questioned, but the process and how it impacts on the professional is.

**7. To what extent does any value stance adopted affect claims?**

a)

The value stance is not acknowledged nor explained

b) How may any explicit or implicit value stance adopted by the authors affect their claims? (e.g. have they pre-judged the phenomena discussed? are they biased? is it legitimate for the authors to adopt their particular value stance? have they over-emphasized some aspects of the phenomenon while under-emphasizing others?)

The authors' implicit value stance means that the need for formal admission is not questioned. In turn, this perhaps affects the particular claim that violence and aggression is present and professionals need training to deal with this potential.

**8. To what extent are claims supported or challenged by others' work?**

a) Do the authors relate their claims to others' work? (e.g. do the authors refer to others' published evidence, theoretical orientations or value stances to support their claims? do they acknowledge others' counter-evidence?)

There is no reference to others work other than to mention its existence

b) If the authors use evidence from others' work to support their claims, how robust is it? (e.g. as for 5c)

Not used

c) Is there any evidence from others' work that challenges the authors' claims, and if so, how robust is it? (e.g. is there relevant research or practice literature? check any as for 5c)

Yes, please see CA of Quirk – maybe others?

**9. To what extent are claims consistent with my experience?**

The claims concerning the experience reported by ASWs is consistent with my personal work experience. It can be difficult organising an assessment and the process involves careful handling and deployment of skills such as organisation, communication and remaining calm. There is a potential for aggression during the assessment, especially once the assessment has been decided and the transport is awaited. No impact on the therapeutic relationship in my experience. I also experience ASW work as skilful and concur with those noted along with the way in which training is delivered (mixture of theory and practice i.e. learning in classroom and observation of others)

**10. What is my summary evaluation of the text in relation to my review question or issue?**

a) How convincing are the authors' claims, and why?

The authors' claims do not really match the data, but rather come from implicit stance that assessments take place and the process could be strengthened by allowing fewer people to be involved (although this is qualified by saying that this might impact on a person's rights), that all participants should receive breakaway training despite low report of physical violence but reports of verbal and threats. The therapeutic relationship is a helpful consideration in terms of nurses undertaking the role subsequently. The need for interprofessional training they claim appears likely to be of benefit, but this does not discuss the 'critical aspect' nor does it take into account that the required skills are present

b) How, if at all, could the authors have provided stronger backing for their claims?

There is just one direct quote used but this is not attributed. There is no discussion of the other research available or critique of it. Nor is there an orientation into the theoretical context.

## APPENDIX THREE

### *Evaluating the role and experiences of Approved Mental Health Professionals: a phenomenological study*

#### CONSENT FORM

If you are happy to participate please complete and sign the consent form below

Please  
Initial Box

1. I confirm that I have read the attached information sheet (version 2) on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.
2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time up to and during interview without giving a reason and without detriment.
3. I understand that the interviews will be audio-recorded
4. I agree to the use of anonymous quotes
5. I agree to my anonymised rich picture being used to illustrate any findings
6. I agree that any data collected may be passed to other researchers
7. I understand that relevant sections of data collected during the study may be looked at by responsible individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in the research. I give permission for these individuals to have access to this data

My professional background is (please state).....I agree to take part in the above project

---

Name of participant

---

Date

---

Signature

---

Name of person taking consent

---

Date

---

Signature

---

---

---



***Evaluating the role and experiences of Approved Mental Health Professionals: a phenomenological study***

**Participant Information Sheet**

You are being invited to take part in a research study as part of a PhD student project which aims to explore the role and experiences of Approved Mental Health Professionals. Before you decide, it is important for you to understand why the research is being done and what it will involve.

This research has been approved by the University of Manchester's ethics committee and has also received approval from the research group of the Association of Directors of Adult Social Services.

Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

**Who will conduct the research?**

xxxxxxxxxxxxxxxxxxxxx PhD Student School of Nursing, Midwifery and Social Work

**Working title of the Research:**

Exploring the role and experiences of Approved Mental Health Professionals: a phenomenological study

**What is the aim of the research?**

The principal research aim is to explore the function and experiences of Approved Mental Health Professionals from their own perspective. The research is timely. The nature and type of professional mental health roles is changing. This change is a result of Government policy, as encapsulated in legislative reform, which is bringing about new ways of working in the mental health sector in England and Wales. The research aims to provide new insights into the experience of undertaking a role which is directly relevant to the public sector and will be an area of importance to those who undertake it and to those who educate and manage them.

**Why have I been chosen?**

This research aims to explore the experiences of Approved Mental Health Professionals from their own perspective with a view to understanding the functions fulfilled and the psychological and emotional experiences involved. In particular, the research wishes to investigate whether the role when undertaken by professionals other than social workers is fulfilled and experienced differently.

You have been chosen to consider being involved as you are a practising Approved Mental Health Professional with at least one year's experience. The research will involve up to 20 participants from the range of eligible professional backgrounds. The plan is to recruit from each professional background.

### **What would I be asked to do if I took part?**

Each participant will be asked to undertake a semi-structured interview. The interview will be based on a schedule put together before the interview. The schedule will be piloted beforehand by the researcher. The interview will take place in a work place setting convenient for the participant and should take no more than one and a half hours. The interview will be audio-recorded and later transcribed by the researcher. At the beginning of the interview participants will be asked to draw a rich picture using pens and paper provided by the researcher. Participants will be asked to describe their rich picture as part of the interview.

Rich pictures are a relatively new method in social work research. They were first used in the 1980s as a way of depicting complex organisational systems and are created by drawing symbols to depict a situation. The participant will be asked to produce a rich picture of their designation as an AMHP by depicting compulsory mental health assessments in which they were the applicant. The aim of integrating discussion of a rich picture in to the interview is to explore the experience of undertaking an application. The creation of a rich picture should take no longer than ten minutes. An example and information about rich pictures is attached.

### **What happens to the data collected?**

The data will be collected by transcribing the audio-recording of the interview. Each transcript will then be analysed for themes and will be compared with one another for similarities and differences. The rich pictures and the description of them by the participant will also be analysed by the researcher. The data will provide the basis of the findings of the research.

### **How is confidentiality maintained?**

Each participant will be asked not to use identifiable names or places. The transcription and recording will also be guided by the need for data to remain anonymous. This rule will also apply to the rich picture which should also not depict the names of people or places.

The names and contact details of the participants will be stored in a locked facility in the University which will only be accessed by the researcher and supervisors. Participants will be coded. This list will also be stored in a separate locked facility in the university. All transcripts will be stored electronically on a password protected laptop used only by the researcher and not left unattended. When not in use the laptop will be stored in a locked facility.

Study data and material may be looked at by individuals from the University of Manchester, from regulatory authorities or from the NHS trust, for monitoring and auditing purposes, and this may well include access to personal information

**What happens if I do not want to take part or if I change my mind?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time up to and during the interview without giving a reason and without detriment to yourself.

**Will I be paid for participating in the research?**

Participants will not receive any payment for participating in the research.

**What is the duration of the research?**

Participants will be asked to be available for one session lasting no more than one and a half hours. The session will include time for producing the rich picture and a series of questions based on semi-structured interview schedule. The questions will be devised by the researcher beforehand and piloted.

**Where will the research be conducted?**

The research will be conducted in a work place setting of the participant's choosing.

**What happens if I disclose an issue which might be perceived as inappropriate conduct?**

If during the any stage of the data collection an issue arises which might be perceived as inappropriate conduct, the researcher will alert the participant to this and will then discuss this with the supervisors of the research. If the issue is deemed serious, this will be raised by the researcher's supervision team with the participant's line manager. Any data collected at this point will not be included in the study

**Will the outcomes of the research be published?**

The findings will be included in the researcher's PhD thesis and will also be put forward for consideration for publication in relevant journals and books. This might include the revision of text book for AMHPs for which the researcher may receive royalties. Dissemination will also take place to local authorities with social service responsibilities.

**Criminal Records check (if applicable)**

Not applicable

**Contact for further information**

E-mail: xxxxxxxxxxxxxxxxxxxxxx

Telephone: work mobile xxxxxxxxxxxxxxxxxxxxxx

**What if something goes wrong?**

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If they are unable to

resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Co-ordinator on 0161 275 7583 or 0161 275 8093 or by email to [research.complaints@manchester.ac.uk](mailto:research.complaints@manchester.ac.uk)

## Rich Pictures

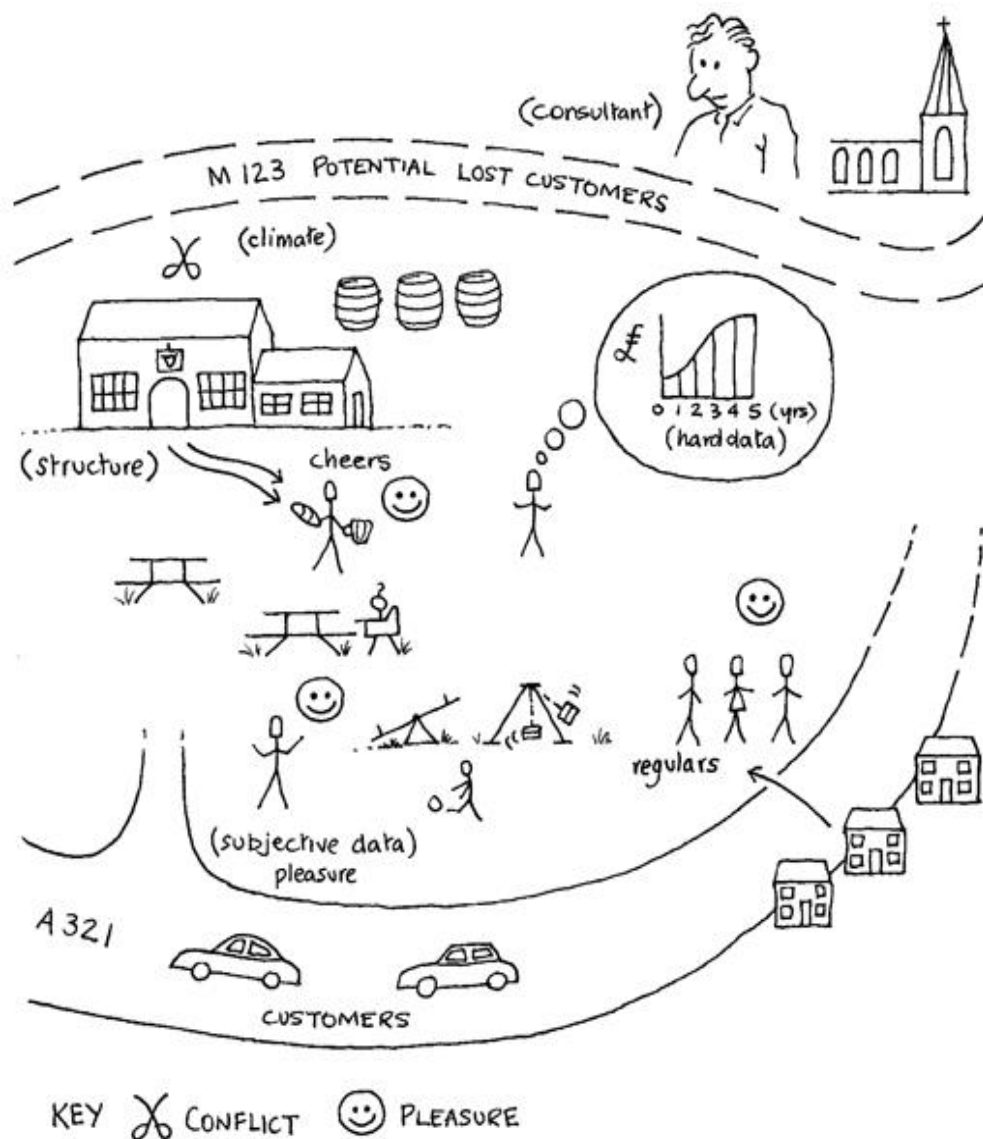
A Rich Picture is intended to portray the unstructured situation with which you are confronted, in this instance you are asked to think about and portray complex compulsory mental health assessments in which you have been involved.

Think about compulsory mental health assessments in which you have been involved as the decision maker or applicant:

- 'Dump' all the feelings, thoughts and images of the scenario(s) you are experiencing in an unstructured manner on to the piece of paper, using symbols and caricatures. Remember your ability to draw is not being judged!
- Include hard factual, data and soft subjective information in the picture. Please remember that everything should be anonymous.
- Look at the roles which appear meaningful, e.g. service user, professionals and relatives. Again please remember not to use real names of people or places.
- Annotate the Rich Picture with footnotes where appropriate.
- Include yourself in the picture.
- Give the Rich Picture a meaningful title.
- You will be asked to describe the picture during the interview

An example of a Rich Picture is shown below, depicting the author's view of a country pub facing a change in custom due to a new motorway being built around, and bypassing, the village in which it is situated. This is only part of a bigger Rich Picture which would be required to depict the whole scenario but it does demonstrate how a rich picture looks.

Remember, your rich picture is not meant to be a work of art but a working tool to assist you in your understanding of the experience of undertaking compulsory mental health assessments. You will be asked to talk about your picture during the interview



*Part of a Rich Picture of 'Country Pub and Motorway' scenario*

Checkland, P. (1980) *Systems Thinking and Practice*, Chichester, Wiley Farmer, E.S. Tutorial Case Study for T245, The Open University

## APPENDIX FOUR

Figure A4.1 Breakdown of sample showing gender, professional background and longevity

Professional background	Gender	Length of time as an approved mental health practitioner
Social worker 01	Male	Over 15 years
Social Worker 02	Male	Over 5 years
Social Worker 03	Female	between 5 and 10 years
Social Worker 04	Male	Between 5 and 10 years
Social Worker 05	Female	Over 15 years
Nurse 01	Male	2 years
Nurse 02	Female	1 year
Nurse 03	Male	2 years
Nurse 04	Female	1 year
Nurse 05	Female	2 years
Occupational Therapist 01	Female	2 years
Occupational Therapist 02	Female	2 years

## APPENDIX FIVE

### *Exploring the functions and experiences of Approved Mental Health Professionals; a phenomenological study*

#### **Topic Schedule**

##### Preamble:

Reiterate reason for the interview by revisiting the participant information sheet and checking whether they are clear and if they have any further questions.

Revisit the consent form and ask them to sign two copies, one of which they will keep and one which will be kept by the interviewer

Reassure them that the interview will last no more than one and a half hour and that they can choose to end it and remove themselves from the study up until the point of data aggregation.

Check that they have agreed to produce a rich picture about their experiences of compulsory mental health assessments and explain that they will be allowed up to fifteen minutes to compile a 'rich picture' using the pens and paper provided.

Reiterate that I am not looking for right or wrong answers and that they should take their time.

Reiterate the need for confidentiality and that all names and places used should be anonymous.

Remind them that should there be any disclosure of unethical practice, the interview will need to cease and the researcher will need to raise the matter with their supervisor at the university and agree what further action is needed. Any data collected to that point will not be used in the research but may be retained and shared on request.

Reiterate that the session is being audio recorded and will be transcribed.

Acknowledge that sensitive issues might come up and I can put them in touch with someone should they need to discuss these after the interview.

Allow 10 minutes for production of rich picture talk through the attachment and let person know that you will leave them alone to do this and return when time is up to begin the interview which will be recorded using a tape recorder.

Leave room

Return and begin interview

### Interview Schedule

Can you tell me about you as an Approved Mental Health Professional? (*Prompts: your professional background? How long have you done this role? Approximately how many assessments have you undertaken? What do you believe are the most important aspects of the AMHP role? Can you describe any aspect in detail? Are there any aspects that you think are more important?*)

Can you please talk me through the rich picture which you created? (*Prompts: please describe the picture. Did anything surprise you when you were drawing it? Is there anything in the picture that you found difficult to portray? Is there anything that didn't come up that they were expecting to come up?* )

I would like to find out more about your experience of being an AMHP (*Prompts: how do you feel? With whom do you consult and why?*)

Can you say what your view is on the AMHP role being open to a range of professionals? (*Prompts: can you explore this view in detail?*)

Is there anything you find difficult about being an Approved Mental Health Professional? (*Prompts: Can you describe this? Can you say how this makes you feel? Can you say what helps you to deal with this?* )

What do you think hinders good AMHP practice? (*Prompts: are you able to give an example? Can you say how this makes you feel?*)

What do you think is good AMHP practice? (*Prompts: are you able to give an example? Can you say how this makes you feel?*)

Is there anything else you would like to add?

### Closure

Clarify the process after interview:

Remind them that the tape recording will be transcribed and check if they would like to see a copy of the transcription for information?

Transcriptions will be seen by another colleague for validity checking, but names will remain anonymous.

The data will be stored and will be destroyed 10 years post study completion in line with the University's policy on data storage and retention.



The findings will be used for a doctoral thesis, and, if applicable, publication in academic journals and books. Books might include a new edition of a text book on Approved Mental Health Practice for which the researcher will receive royalties.

Remind them who to contact if they have any questions or concerns regarding their involvement.

Thank them for their time